Please Type of Print im Black Indelible in 12 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7,11 per fh g931 9-27-12 vt.
Registrar

State of Maryland / Department of Health and Mental Hygiene 20 | 2 28501 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August ROBERT ASPER WACHTER JR 16, 2012 2:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 220-26-0379 1 X M 2 □ F Yrs. April 4, 1929 Maryland 83 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ¥ Yes 2 □ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21788 U. S. A. 6524 Mountaindale Road or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 ☐ Never Married 2 🔀 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Noted 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natui other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert A. Wachter, Sr. Mildred Keeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6524 Mountaindale Road, Thurmont, Md. 21788 Margaret Wachter - Wife 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 8/21/2012 Mt. Prospect Church 4 Donation 5 Other (Specify) Lewistown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike, Frederick, Md. 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Due to (r as a nsequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam 9 ☐ Unknown 1 L Yes 2 L 9 Unknown the detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an thin 24 hours after death.

the Funeral Director: After this certificate has autopsy filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 2 No မ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) . Registrar's Signature State AUG Registrar

DHMH 17 Rev 06-2011

28502 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 8 Physician/ 7:07 PM Charles Wachter 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death Many land Medical 8. Date of Birth
Jan. 9, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 216-22-8855 86 1 XM 2 □ F Director Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director notified 28a-f Maryland Frederick Frederick 1 X Yes 2 □ No 10f. Zip Code 21702 5 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a o Examiner must be 500 Wilson Place Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

XX Yes 2 □ No or i Completed by 1 Never Married 2 X Married XX Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WW II White 3 Widowed 4 Divorced Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Wholesale/Supplies Owned & Operated Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ralph Franklin Wachter Helen Gosnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Mrs. Mary Jane Wachter, wife 500 Wilson Place, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Cemetery, crematory or other place)
Mount Olivet Cemetery Aug. 23, 2012 1  $\underline{X}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD M00255 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner weeks DESTRICATION APPROVED BY MEDICAL EXAMINER Phenmonia Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Hospita Other: 잍 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury Natural 5  $\square$  Pending from standing 1 Yes 2 No 2 Accident Investigation 07-10-2012 8:00 AM 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Rumber, City or Town, State) determined Frederick 500 WILSON Home 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 68678 08-17-2012 124 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Silhan South Greene MD 21201 22

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Mary Jo Willis UGUST 15A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 137-20-7642 92 1 □ M 2 🛣 F May 30, 1920 South Carolina 10c. City, Town or Location 10d. Inside City Limits Prince George's Upper Marlboro 1X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12312 Ronald Beall Road 20772 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 😾 No Specify. 3X Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Chef Hotels 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Unknown Cora Rainey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1823 Erie Avenue, Atlantic City, NJ 08401 Morris Washington/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Qurial 2 X Cremation 3 - Removal from State 8-14-2012 4 Denation 5 Coner (Specify) Baltimore, MD 2. Name and Address of FacilityBeall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Acute Respiratory Failure Due to (or as a consequence of): Pulmonary Edema Dish to (or as a nonsequence of) Hypertensive Emergency Due to (or as a consequence of): Acute Kidney Injury yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) Yes 2 No Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ 6 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician/ Medical Examiner

attending physician for use as the buria

Physician/

Medical

Director

Completed by Funeral

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**Examiner** 

**Funeral** 

**Director** 

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item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu

1 and 2 should be how. of Health and Mental Hygiene. \*\*\*am 27 is marked other than "n "- went, the Med

permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traums

death with the Maryland ms 23a or 28a-f sho must be notified at

filed within 72 hours after

Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pancreatic Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month

13

2012

29c. License number

D0052

The law requires that the death certificate be executed s certificate has build in the country of the count To the Hospital or Attending Physician: funeral director, within 24 hours a

To the Funeral C completely

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year) AUG 15 2012

mare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one

29b. Signature and title of certifier

Amare Abebe MD 8118 Good Luck Rd., Lanham, MD 20706

Specify: White 16b. Kind of Business/Industry Eastern Airlines 20c. Location - City or Town, State Glen Burnie, MD Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month. Day, Year)

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 XNo

PA

IISA

State Registrar Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 10:30 September Medical Elijah Rahman Abdullah 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care, Inc. Towson If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Min. Director 1 😾 M 2 🗆 F Aug 2, 1955 New York 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "neturel", or items 23e or 28e-f ehow other treumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Cooksville Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21723 2320 Rt 97 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 2 1 ☐ Never Married 2 😡 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nutrition dietary work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlese Porter Elijah Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Rt 97; Cooksville, MD 21723 Theresa Smith-Abdullah - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of importent: If its any injury or of 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Prvice Licensee 22. Name and Address of Facility State Anatomy Board **Virector** 655 W. Baltimore St; Baltimore, MD 21201 m 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chlonic Friysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to incrediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: After this cartificata has bean signed by the attending physician and funeral director, page 2 should be detached for use as the burlal-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 10 No 25. Was case referred to medical examiner? **Division of Vital** æ 26. Place of Death (Check only one) Other: 4 🗌 Nursing Home 5 🗆 Residence 6 💆 Other (Specify) 1 ☐ Yes 2 💆 No 1 Inpatient 2 ER/Outpatient 3 I DOA မူ in 24 hours after death.

he Funerei Director: After this or pietely filled in by the funeral dii 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical within 24 hound to the function of the functio 29a. Certifier TZ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

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tow son us

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28506 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 1, 2012 Gordon Alan Achilles Physician/ 6:15 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery Manor Care Chevy Chase If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Director 165-26-0714 1 X M 2 □ F 76 July 15, 1936 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. anti of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-1 sho 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medicel Examiner must be notified at Director 1 X Yes 2 No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral # 1108 4200 Cathedral Avenue, N.W. 20016 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1961—1966 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Congress 5+ Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Christy Leonard Achilles Ida Anna Zadach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Lynn Franks / Friend 2401 Pennsylvania Ave, N.W. #701, Washington, D.C. 20037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot competent, crematory or other place)
Montgomery
Crematorium, Inc. 1 Durial 2 Cremation 3 Removal from State September 5, Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Signature of Juneral Service Licensee M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Lewy Body Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 2 🕅 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA |2 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause (s) and manner as stated to the cause (s) and manner as taken to the cause (s) and manner as taken to the cause (s) and manner as taken to the cause (s) and the cause (s) are cause (s) and the cause (s) are cause (s) and the cause (s) and the cause (s) are cause (s) and the cause (s) are cause (s) are cause (s) are cause (s) and the cause (s) are cause only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sunitha Bhogavilli, M.D.

7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9801 Georgia Avenue,

29c. License number

D54566

29d. Date signed (Month, Day, Year) September 4, 2012

#1-17, Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #10a f Per FH &26 Per PHY G931 State of Maryland / Department of Health and Mental Hygiene 20 | 2

28507 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2012 7:55 a<sup>M</sup> Martino Almogela Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8945 Griffin Way Pikesville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 86 Director 219-40-5529 1 🛚 M 2 🗆 F Jan 30, 1926 Philippines Usual Residence of Decede 10b. County Flagler shov 10a. State 10d. Inside City Limits items 23a or 28a-f shoner must be notified at Palm Coast Directo 1 Yes 2 No MD Baltimore Pikesville 10e. Street and Number 41 10f. Zip Code 10g, Citizen of What Country? 32137 Fieldstone Lane Funeral U.S.A. Griffin Way 21208 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Filipino Completed 3 

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Anesthesiologist Northwest Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
fitem 27 is marked ot
r other traumatic ever မ Maines Fausta Almogela Paterno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Eleanor Kruter Daughter 2150 Warm Forest Drive Finksburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation Inc. 9/10/12 4 Donation 5 Other (Specify) Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ze Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequer or of: or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Tyes 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Second Other: 1 🗌 Yes 2 □ No Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence the funeral 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 5, 2012 Carl Frederick Adkins 12:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 219-34-1128 1 XM 2 □ F Sep. 28, 1937 74 Maryland Usual Residence of Decedent it if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Harford 1 Yes 2 XNo Maryland Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 600 Hookers Mill Road a.m. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married 2 X No ☐ Yes 215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Local Union Steamfitter Baltimore, Maryland 21 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Percy Coleman Adkins Wilhelmina (unk) Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shart of Health a 600 Hookers Mill Road, Abingdon, Maryland, 21009 Patricia Adkins / Wife SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important; If any injury or 9/8/12 Joppa, Maryland Union Chapel UMC Cem: 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1mas 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause (Disease or injury that initiated events Due to for as a nonsequence of or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last Director; After this certificate has been signed by the attending physician Be Completed by Physician/Medical Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant

examiner?

29a. Certifier

1 🗌 Yes

in the past 12 months?
1 ☐ Yes 2 ☐ No g Unknown

2 **X** No

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify) g Unknown

23d Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a, Was an

24b. Were autopsy findings available prior to completion of cause of

Year

25. Was case referred to medical 26. Place of Death (Check only Hospital: Other: ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 28c. Injury at 28d. Describe how injury occurred

27. Manner of Death 28a. Date of injury 28b. Time of (Month, Day, Year) 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 4 🗌 Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. CRNP TRACIE L. MORGAN, TIMONIUM, MD 21093

State Registrar

the funeral director, page 2 should.

filled in by

Certificate: To

Medical

DHMH 17 Rev 06-2011

ADKINS

Division of Vital

Hospital within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, 19b, perFH, G932, 10/11/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar 28509 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08/21/2012 Bailey JOHU 4:18A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MARYland HOSPITAL SOUTHERN linton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 578781668 1 ■M 2 □ F Director WasHIDC 1959 or 28a-f show notified at at 10b. County 10c. City, Town or Location with the Maryland Director MD G APITAL 1 Pres 2 No HeIGHT'S 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? must be iral", or items 23a Examiner must be Funeral Blvd SA APITAL HEIGHT'S 20743 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Specify: Black Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH noineel DSDA Department of Health and Mental High Important: If item 27 is marked other any injury or other traumatic event, I once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK ဂ Bailer EIIA ess 196-1917 Address (Street and Number or Aural Route Number, City or Town, State, Zip Code)
717+ CAPITAL HEIGHT'S BIVEL, MD 120743 19a. Informant's Name/Relationship (Type, Print) DAiley - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State rentwood, MD Fort incoln 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 420 HSTIME B.K. enru tuneral Home MIX" ZCCOS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or neart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph, sician/ CEREBROVASCULAR Onset and Death ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, hadding to immediate Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 as the l IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION of Vital Records, Hospital or Attending Physician: The law requires cate has been signated; Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate 2 No 1 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Division Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064986 22 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surratts Rd, Clinton MD, 20735 CHIKE )NWUKA 7503 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 7 2012 arks Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death nt's Name (First, Middle, Last) 3. Time of Death Physician/ 1:30P M Deptember 2012 Medical institution, give street and number, City, Town, or Location of Death Examiner Baltimore atonsville ane Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) -16-6523 Director 1 M M 2 - F Usual Residence of Decedent permit. Pege 1 end 2 should be flied within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan instrust be notified at once. 10a. State 10b. County City, Town or Location Director 10d. Inside City Limits atonsvill Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Maryland £1215-0036 1 ☐ Yes 2 Mo Specify: Completed 3 Widowed 4 Divorced ack 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working met DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) nsportation 6th Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Aga. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 210Winters Lane, Unit A, Catonsville, Ynd arolyn Scott Baltimore. 20a. Mether of Disposition 20b. Place of Disposition Name of 1 Burial 2 Cremation 3 Removal from State Hrbutus 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licensee Greene Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease Immediate Cause (Final Physician/ OYOV disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). attending physician and I for use es the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an i after death.
I Director: After this certificate has to in by the funeral director, page 2 to autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral D completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check 29b. Signature and title of certifier ny 36942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Cetargrille, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28511 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mon1 08 2012  $A^{M}$ Sister Frances T. Balsamo 9:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4130 Maple Avenue Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months 1 □ M 2 🕱 F (Month Day, Year) 11/01/1913 199 40 8639 Director 98 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland **Baltimore** Baltimore 1 🗌 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4130 Maple Avenue 21227 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5 years Seamstress/Infirmarian years Religious Sister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even Salvatore Balsamo Josephine M. Capo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Nora Pat O"Flannigan 4130 Maple Avenue Baltimore, Maryland 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State New Cathedral Cemeter 09/04/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ₽nysician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Zuneral Director, After this certificate has been signed by the attending physician and completed lilled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death' Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 XNo Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Fractioner: To the best of my knowledge stands from under three stets sont artists by 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) S autin 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MARTIN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner G PPERCO CTIMORE HUNTEN RESN 1 Year If Under 24 Hrs.
Davs Hours Min. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day If Unde 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Country) when Englance Director 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No imore oercc 0f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Ves 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 K Divorced Completed nhite the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Nife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) a iane Be 18. Mother Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Doesco over - executa 20a: Me hod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Forest 4 Donation 5 Other (Specify) Yorkld Signature of Funeral Service Licenses 22. Name and Address of Facility 169 24 Monkton MD 2111 JELVICES Monkton 23a. Part 1. Enter the disease shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final LATERA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) YX **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the a detached f ☐ Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed a certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည this within 24 hours after user...
To the Funeral Director. After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred Natural iniurv 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Luch Klavin É, HARD 31. Date filed (Month, Day, Year) 32. Registrar's Sgnature State **SEP 07** Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#20b, perFH, G931, 9/7/2012, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Sept. Physician/ 2012 4:40 A Buddy Winnifred Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Months 148-32-2767 97 **Director** 1 □ M 2 🕅 F June 29, 1915 West Indies Usual Residence of Deceden an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1 Yes 2 XNo MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13022 Conductor Way 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify Black 3 XVidowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) other traumatic event, the Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) itn and Mental F. 7 is mark ပ Loney Dickson Prince Edward Eleanora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important if item 27 is any injury or other traun 13022 Conductor Way, Silver Spring, MD 20904 Erlinda Buddy / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 certification (value of certification) certification (value of the place) to the of the certification (value of the place) to the office of the certification (value of the place) to the certificatio 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/10/2012 Silver Spring, MD 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ble Onset and Death Immediate Cause (Final →Physician/ 12200 disease or condition resulting in death) Medical Due to r as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Vear Pregnant at time of death the 1 | Yes 2 | 9 | Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ grolu 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed peen Dementa. 24b. Were autopsy findings available prior to completion of cause of death? has autopsy Dicelata mellitui performed' 1 Yes 2 No 2 No this certificate To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1. Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/1/12 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , pringers of it # word signal logp, Wing ord with 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Denn S. parle

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 201 8:39 AM Physician/ August 31, Ann Thompson Bibro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 B Hogarth Circle Cockeysville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | Jul 09, 1955 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Onio 57 Director 288-56-4392 1 🗌 M 2 🔼 F 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21030 5 B Hogarth Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Health Care 12 Nursing Assist. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Caldonia Crockett Clough Thompson 1 end 2 should b of Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Bibro /Husband 5 B Hogarth Circle Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sep 08 20c. Location - City or Town, State permit. Page 1 e
Department of H
Importent: If ite
eny injury or ot
once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Beltsville, Maryland 2012 4 Donation 5 Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician nd disease or condition resulting in death) Medical Due to (or as a consequence 1) Examiner typertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examine ettending physician end I for use es the buriel-trensit that initiated events resulting in death) Last The law requires that the deeth certificate be execut Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the elid be detached for 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hepatitis Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 hes page 2 e Hospitel or Attending Physicien: The 124 hours after death. e Funeral Director: After this certificate I letely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5  $\square$  Pending Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature ar cause of death (Item 23a) (Type, Print) 3 734 YORK ROAD, L

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 1:22 A M Richard Lee Braboy -30-2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospica et Sal'sbury Wiesmies Coastal Lake the Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Days Min (Month, Day, Year) 69 Director 212-40-9645 1 🛛 M 2 🗆 F Usual Residence of Decedent Maryland permit. Paga 1 and 2 should be filed within 72 hours after daath with the Maryland Department of Haatilt and Mertal Hyglana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at any injury or other traumatic event, the Modical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 735 West Rd; Unit B 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 196

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc. β 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** 3 Divorced 4 Divorced 1969 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) machine operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Helen Florine Camphor Lee Richard Braboy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code, 735 West Rd; Unit B; Salisbury, MD 21801 Alece Deshields - daughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Prevel Service Licens 22. Name and Address of Facility State Anatomy Soard 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON Physician/ MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes ZIN Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No HOSDILE မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAR

31. Date filed (Month, Day, Year)

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9 04 PM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** NIA 10 -11mon 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Numbe 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Hours Min. **Director** 1 🗆 M 2 🗗 F GARO HNA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married by Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO,NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any scaling to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month 5 Other (specify) Day Year 9 Unknowh Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending work? 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier H0064767 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Control Bluer 31. Date filed (Month I

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State Registrar

75

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G931, 9710/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 3 1. Decedent's Name (First, Middle, Last) Month 13:45 PM Physician September Delores Butler 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Raltimore 8. Date of Birth (Month, Day, Year) 1–25–1938 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F Days Hours 74 Yrs. 219-32-2315 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 ☐ No BALTIMORE Director MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21205 USA Mc Eldery STREET Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) USTODIAN SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be f JOHNSON WILBERT if Health and Menta Item 27 Is marked LILLIAN MOORE Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) SHARON MUSE 2510 Edge combe Circle Apr G · BAGO, MD · 21215
ce of Disposition (Name of Date 20c. Location · City or Town, State DAUGHTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition /15/2012 BALTIMORE, Md permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State UNK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SULS 4905 York ROAD. BALTIMORE, Md. 21212 23a, Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Stroke **Physician** /Medical resulting in death) Due to (or as a consequence of): herniation (Stroke Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: ase 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day atter I for Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Unknown 1 Yes director, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗆 No 1 ☐ Yes 2 No 1 Tyes certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 1 ☐ Yes 2 INo 2 ER/Outpatient 3 DOA ည this 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 September 3, 2012. mo. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Jessica Klein 31. Date filed (Month, Day, Year) **SEP 0 7 2012** 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

12-06622 Charles Beranek Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	F	- For State Registrar	Cert	ificate of	Death			Reg.	No.	
Physicia	n/	Decedent's Name (First, Middle,Last)					Mon	of Death th D	)ay Year	3. Time of Death 0905 hrs
Medical Examir		Charles R. E  4a. Facility Name (if not institution, give street and r	eranek	4	o. City, Town,	or Location of		tember	4c. County of Death	
		Shady Grove Hospital	,		Rockville				Montgomery	
Funeral	T	5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Y	ear If Under	1		(MM/DD/YYYY) 9. Bir Foreig	on
Director	L	364-34-0577   1 <sup>™</sup> <sub>1</sub> M 2 F	77	Yrs.	Worldis	ays Hours	Ap	ril 2	5, 1935 co	ountry) Michigan
any		Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Location	ะก					10d. Inside City Limits
		Maryland Montgomery		Rockv	ille					1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number			10f. Zip Code	•		10g	. Citizen of What Cou	ntry?
with the Maryland ms 23a or 28a-f sho be notified at once		16901 Olde Mill Run			2085				United Sta	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed	cedent Ever in U.S Forces?	S. 13. Was	Decedent of s, specify Cul	Hispanic Origii pan, Mexican, I	n? ( Specify Ye Puerto Rican,	es or No- etc.)	14. Race - Amer White, etc.	ican Indian, Black,
ter dea		1 X Yes Widowed 4 Divorced If Yes, Give You	2∐ No ≈r 1957–1963	3 1 🗆	Yes 2 X	No specify:			Specify: W	hite
ours af atural camin	<u>و</u>	15. Decedent's Education (Specify only highest gra	ade completed)	16a, Decedent		pation (Give ki life. DO NOT u		ne 1	6b. Kind of Business/	Industry
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)	Econo	•		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Trade Ass	ogistion
5-005 ed withi tygiene. other ti	탉	17. Father's Name (First, Middle, Last)		ECOIL	JIII S C	18.Mother's	Name (First, I	Middle, Ma	iden Surname)	OCIALION
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	George F. Beranek					othy Wo			
D 21 should and Me 7 is ma	유	19a. Informant's Name/Relationship (Type, Print )		VI.	•				er, City or Town, State	
≥ pud a maga	ŀ	Ann F. Beranek / Wife  20a Method of Disposition		lace of Disposit	ion (Name of	cemetery,	Date	12	Le, Maryla: 20c. Location - City or	Town, State
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 Removal	iioiii State	rematory or othe e of Heav			Septeml	per	Silver Spri	ne. Marvland
Baltimore permit. Pages I Department of F Important: If i	$\mathbf{I}$	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee				-			Rockville, I	
E E P		(Ingelette Bright	M013	05   300	West Mon	ntgomery	Avenue,	Rockv	ille, Maryla	nd 20850-2805
Physician		233. Part I. Enter the disease, or complications that failure. List only one cause on each line.		Do not enter th	e mode of dyl	ng, such as ca	rdiac or respira	atory arresi	t, snock, or neart	Approximate Interval Between Onset and Death
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Ir	juries a consequence of	):						-
		Sequentially list conditions, b								
-	ije.	cause. Enter Underlying Cause	a consequence of	):						
rd sit	Examiner	everto resulting in dealing Educ	a consequence of	):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>g</u>	UNPENDED d. AMENDED								
60, ate be exe ohysician a	Medical		, outcome of pregn	ancy					23d. Date of deliver	у
Sox 687 death certific e attending r for use as th	jan/	23b. Was decedent pregnant in the past 12 months?	birth mant at time of dea		al death	3 Ectopic	pregnancy		Month	Day Year
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unk		5 ∐ Oth	er (Specify)				L	
b.O. B that the d		Part II. Other significant conditions contributing			nderlying caus	se given in Par			acco use contribute to	the cause of death? bably 4 Unknown
S, P.( uires that an signed Id be det	Completed by	Hypertensive Atherosclerotic Cardi	ovascular Dise	ease			— ∟	la. Was an		utopsy findings available
cord law req has bee	plet						_ [	autopsy	prior to	completion of cause of
tal Rec	ទ				26 01	ace of Death (		Yes 2	No1 ✓ Y	es 2 No
Vital Records, ysician: The law requiin his certificate has been a director, page 2 should	m	25. Was case referred to medical examiner?	Inpatient 2	ER/Outpatient			Nursing Home		esidence 6 Othe	er:
of V ing Phy After th	٤	1 Yes 2 No 28a. Da	e of Injury th, Day,Year) D:	28b. Time of Ir		njury at Work?	28d. D		w injury occurred	
ion ttendir leath. for: A	aţi	2 Accident Investigation Sep 2	2012	FOUND: 0814 hrs		Yes 2	No ,			
Division of Vital Records, P.O. fall or Attending Physician: The law requires that the staff cleath.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be deaced.	Certification:	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At ho		t, factory, offic	e building, etc	28f. Lo	cation (Str Town, Sta	reet and Number or Ri ite) I Run, Derwood, MI	ural Route Number, City
Division of Northe Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After t		4 Homicide  29a. Certifier A Codificing Physician: To the h	Single Fam		ed at the time	, date and place				
o the Bithin 24	Medical	one) 2 Medical Examiner: On the basi and manner	s of examination ar	nd/or investigati	on, in my opir	nion, death occ	curred at the tir	ne, date ar	nd place, and due to th	ne cause(s)
E 2 E 8	Me	29b. Signature and title of certifier				ense number		- 1	29d. Date signed (Mo	
		1. W.			0.	C.M.E.		1	September 3, 20	J 1 Z
X		30. Name and address of person who completed ca Jack Titus MD. Deputy Chief Med			Baltimore S	treet, Balti	more, MD	21223		
St	ate		Registrar's Signatu							
Regist	rar	CEDITY VIIIZ / March	un A.	Jan Charles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28519 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 2, 2012 Physician/ 1:00 Betty Jean Baldwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase Brighton Gardens If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Days Hours 359-20-9035 Director 1 □ M 2 🗓 F 90 Yrs March 19, 1922 Illinois Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Chevy Chase Montgomery 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? 5555 Friendship Boulevard # 531 20815 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ី No Specify. Specify: White 3 X Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Education Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Paul Taylor, Sr. Ruby Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Baldwin / Daughter 6400 Wishbone Terrace, Cabin John, Maryland 20818 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 20a Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Moffreson Cremetory or other place) Crematorium, Inc. September 6 1 Durial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction Minutes disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Examine if any, leading to immediate cause. Enter on Janying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ¥ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Congestive Heart Failure 24a. Was an autoosy performed? Yes 2 \ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6 K Other (Specify) ၉ 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 IDOA completely filled in by the funeral 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Accident 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 4, 2012 nen D34590

State Registrar Wisconsin Avenue # 211, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fried,

M.D

58

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ beedixon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore N/A Ba/rimine 0+ If Under 1 Year If Under Months Days Hours 6. Sex Funeral 223 - 46 - 061 5 7. Age (In vrs. last birthday) 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min 07/27/1939 New York Director 1 🗌 M 2X F 73 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Randallstown 1 🗆 Yes 2 🛣 No Baltimore CO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ŭ.s.A. Funeral 21133 4108 Springsleigh Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⅓ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. δ 1 Never Married 2 Married Carol Carol daron1 Yes 2 No Specify: Black Specify: "natural" 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Public Defender's Investigator year other traumatic event, Be Maryland 18. Mother's Name (First, Middle, Maiden Surname)
O'Reda Greene 17. Father's Name (First, Middle, Last) Earl A. Dabney 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) 4108 Springsleigh Rd., Randallstown, MD Derrick Dixon(son) Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Carcemation 3 Removal from State 08/31/12 Baltimore, MD on-site Crematory 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 3 Oseph ddrs Brown Jr. Funeral Home 21217 MD2140 N. FUlton Ave., Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Brar h Physician Troxic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 2 🗌 No g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 DN director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death, Funeral Director: After this etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examinor: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragnitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) home 31. Date filed (Month, Day, Year, State Registrar M DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 460 COLLINI 5.50 A M 2012 02 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death MIT Perrina Darkway Center Baltimore N/A If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Director 219-38-3475 1 🔀 M 2 🗆 F 04/28/1930 Italy 82 28a-f show 10b. County 10c, City, Town or Location with the Maryland 10d. Inside City Limits Director be notified MD N/A Baltimore 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 5539 Plainfield Avenue 21206 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene.
Diportant: If iten 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black. White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Personal Care Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ဂ Collini Guiseppe Angela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5539 Plainfield Avenue, Baltimore, MD 21206 Mary Collini, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2012 Baltimore, MD Most Holy Redeemer 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner or as a consequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury tranand that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical and Ventranter tuchyco as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) the attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 L be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cendiumyyzath 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Disear this certificate the funeral director, 25. Was case referred to dedical Be 26. Place of Death (Check only one) examiner? 2 **W**No Other: ုင္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Atural 5  $\square$  Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Certificate: within 24 hours after death. To the Funeral Director: After 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 24 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 31464 9/5/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EVITAN ST Sink 308 BALTIMORE MD 21201 MD A HASKIMI 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	laryland / De			ınd Menta	al Hygi	ene		0.0	-00
			State Registrar		С	ertificate of L	Death		Re	eg. No.2 ()	2	<u>28</u>	<u>522</u>
	Physicia	n/	Decedent's Name (First, Middle, Last)					Mo	e of Death		Year	3. Time o	
يعتلير	Medic	al	4a. Facility Name (if not institution, give s		Coulso	1 4b. City, Town, o	v I rection of		pt.	T		5:40	A M
	Examin	er	Genesis Heritate		Ctr.	Dunda]		Death		4c. County of Balt		re Co.	
*	Funeral		So cial Security Number 6. Sex		ge (In yrs. last birthda	) If Under 1 Year	If Under 24		e of Birth		9. Birthp	olace (State	
	Director			M 2 □ <b>X</b> F	91 Yrs.	Months Days	Hours		nth, Day, \ . 27		Coun	<sub>try)</sub> ry1and	
	nd now at	_	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or	ocation		TED	. 4/9	1721		Od. Inside C	
	arylar a-fst	Director		imore	, som only		I	Dunda1k					s 2 <b>X</b> No
	or 28 e not	Ģ	10e. Street and Number			10f. Zip Code			10	Og, Citizen of Wh	nat Cour	ntry?	
	with s 23a ust b	Funeral	1620 Lynch Road			212	222		ι	Jnited S	tat	es	
	within 72 hours after death with the Maryland giene. ier than "natural", or items 23a or 28a-f sho is, the Medical Examiner must be notified at	Fun	11. Marital Status	2. Was Decedent Armed Forces?		B. Was Decedent of H	lispanic Originan. Mexican. I	in? (Specify Yes	or No-	14. Race	- Americ White,		
36	after I", or xamil	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give		1 ☐ Yes 2 🎛 No		ŕ	,	Specify:			
9	atura ical E	Completed	15. Decedent's Edu	Year or Dates.	16a, De	edent's Usual Occup	pation		1	16b. Kind of Busi		ite	
215	n 72 } an "n Medi	mp	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4 or :	(Gi	re kind of work done of DO NOT use retired)	during most c	of working		Own Hom		adoti y	
7	withi		12 Years	0011090 (1 1 01 1		ecretary/I	Iomemal	ker		Steel I	ndu	stry	
nd	be filed rental Hygricked other	To Be	17. Father's Name (First, Middle, Last)							aiden Surname)			
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Maryland 21215-0036	2 shoul th and 27 is m traum:		19a. Informant's Name/Relationship (Typ		141	iling Address (Street 20 Lynch R				-	ite, Zip C 2122		
	1 and 2 s f Health item 27 other tra		Jeffrey Coulson 20a. Method of Disposition	(Son)	20b. Place of Dis	position (Name of		Date		. y Lanu ?0c. Location - C			
m 0	Page 1		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	, I	ematory or other place Service C		9/6/201	,	Towson	. Me	rv1an	d
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	Johnny		22. Name and Addre Duda – Ruck							-
<u> </u>	8 <b>2 E 8</b>	. /	hry Zx	P		7922 Wise	Ave.	Dunda11	, Ma	ryland			
			23a. Part 7. Enter the disease, or compli shock, o heart failure. List only one	cations that cause cause on each lin	d the death. Do not e e.							Approxima Interval Be	tween
	h sician/	i B	Immediate Cause (Final disease or condition resulting in death)	Chron	ic Obstr	whe I	ulm	oxarya	1500	Ule_		Onset and	Death
	Medical Examiner		resulting in deatil)	Due to (or as	a consequence of):			J					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):						+		
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	HUG	prtens	ion					1		
	execu an an rial-tr	I Ex	that initiated events resulting in death) Last	Due to (or as	a consequence of):								
09	certificate be executed nding physician and use as the burial-transit	dical											
687	rtifica ing ph e as t	/Me	IF FEMALE:		-6								
Box (	death ce he attend ied for us	Physician/Me	in the past 12 months?	3c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal death 3	☐ Ectopic pregnand	су			23d. Date Mont			Year
ğ.	the dea by the a cached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of death .	Other (specify)							/
0.	requires that the death certifica been signed by the attending p should be detached for use as I	by Pl	Part II. Other significant conditions con	ributing to death b	out not resulting in th	underlying cause gi	ven in Part I.	23	e. Did toba	acco use contrib	ute to th	e cause of o	leath?
	uires in sign							_	1 🗆 Yes	s 2 🗆 No 3	☐ Prob	oably 4	Unknown
Š	w required sales	plet						24	a. Was an autopsy		er to co	osy findings mpletion	available
Records,	sician: The law requires certificate has been significator, page 2 should be	Completed						1[	perform	ed?/ de	ath?	2 No	34400
		Be (	25. Was case referred to medical examiner?	anitali.				(Check only or	re)				
<u>-</u>	ding Physician: h. After this certific funeral director,	2	1 Yes 2 No		ient 2 ER/Outpat	. 1	4 Murs			ice 6 🗆 Other			
0	ding I h. After funer	Certificate:	1 V Natural 5 ☐ Pending	28a. Date of inju (Month, Da	y, Year) 200. Time injury	work			scribe how	injury occurred			
20	l or Atten after deat Director; I in by the	rtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm,		163 2 11		ation (Stre	eet and Number	or Rural	Route Numi	ber,
Division of	alor A s after al Direc ed in b		4 - Homicide determined	building, et	c. (Specify)			City	or Town,	State)			
	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director, After this certific mpletely filled in by the funeral director.	Medical	29a. Certifier 1 V Certifying Physic (Check 2 Medical Examine		my knowledge, deat								anner stated
	To the Hospital or Attent within 24 hours after deat To the Funeral Director. completely filled in by the	Me	only one) 3 Gertifying Nurse		is best of my knowled	o, death conumed at t	he time; date:		dus to the	nauso(s) and mar	nnor as s	iteted :	
	<b>≒</b> .≱ <b>6</b> 8		29b. Signature and title of certifier	ides.	CRUF	29c. License		90	29	d. Date signed (i	17	Jay, Year)	
	(1)		30. Name and address of person who col	npleted cause of d	leath (Item 23a) (Type	(Print)	- <u>~</u> 0		<u> </u>	1101	1 2		
	りく		Lubbu Shadis	2 M	orket p	ace	Dun	deulk	, M	D 2	12	$\mathcal{N}^2$	
	Stat		31. Date (SEP n) 7 2012	32. Registra	ar in ignatural	1							- 1
	Registra	ır	λ	- A	7								

Registrar DHMH 17 Rev 1/2001 SEP 0 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

My W

R3MMAHOM

31. Date filed (Month, Day, Year)

IDDU GAV 32. Registrar's Signature

D0070832

29d. Date signed (Month, Day, Year)

821 N ENTAN ST \* 30+ Baltim on MD 21201

			. 101		nt in Blac aryland / I	Depa	rtment	of H	lealth a		•		egible.	0 1
	Physicia Medio		State Registrar  1. Decedent's Name (First, Middle, Last)  ELIZABETH B. CARROLL			Cert	ificate	of D	eath		2. Date of De		20   2 20   2'	3. Time of Death 10:10A M
0	Examin	er	4a. Facility Name (if not institution, give street and STELLA MARIS HOSPICE				4b. City, To	own, or		of Death		4c. Co	BALT	
	Funeral Director		5. Social Security Number  6. Sex  404-20-1519  Usual Residence of Decedent		(In yrs. last bird 9	thday) Yrs.	If Under 1 Months I	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 2	y, Year)	Cou	hplace (State or Foreign intry) KY.
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10a. State 10b. County  Maryland Baltimore  10e. Street and Number		10c. City, Tow	n or Loca			.more	Cour	nty	10- 6	5 \Alba-4 Co.	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
		uneral	2500 Taylor Avenue	Docadant F	uar in 11 S	112 14			212		oifu Voo or No		n of What Cou	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Beach of Health and Mental Hygiene. The Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Y I I I I I I I I I I I I I I I I I I	Decedent End Forces? Yes 2 X X s, Give or Dates.		If	as Deceden Yes, specify	/ Cubar —	n, Mexican	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)	1	Race - Ameri Black, White ecify: Whi	, etc.
	within 72 ho giene. er than "naf , the Medica	Completed		ge (1-4 or 5-		(Give ki life. DO	ent's Usual ( nd of work of NOT use re	done d etired)	ition <i>uring m</i> ost	of worki	ng		of Business/I	
nd 2	e filed wit tal Hygie ed other event, th	To Be C	17. Father's Name (First, Middle, Last)	<u> </u>		Hor	<u>nemake</u>	er			(First, Middle,	Maiden Sur		-Own Home
Maryland	12 should be file alth and Mental 27 is marked of r traumatic eve		John Bernard Burdiss  19a. Informant's Name/Relationship (Type, Print)  Mary Jane Bohlen (Daug						nd Numbe	r or Rura	ces L. <sup>Route Numbe</sup> Baltin	er, City or To		
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition  1XX Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	20b. Place o cemete St. Jo	ry, crema	atory or other	er place	9.	-8-2	Date 012		tion - City or 7	
Balt	permit. Departi Import any inji		21. Ifg a lire of Funeral Service Licensee			7	Name and A	Addres ela	s of Facility	Las I. Ba	sahn Fo	uneral e, Md.	. Home 21236	
	h Medical Medical attending physician and attending physician and for use as the bruial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease of injury that initiated events	MENTIA  e to (or as a  e to (or as a		of): of):	the mode o	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
. Box 68760	res triat the death certifies signed by the attending p de detached for use as	nysician/Me	in the past 12 months?	Live Birth 2	of pregnancy 2  Fetal death time of death		Ectopic pre Other (spec		ý			230	d. Date of delive	very Day Year
Division of Vital Records, P.O	peen	Completed by Physician/Medica	Part II. Other significant conditions contributing	to death bu	ut not resulting	in the un	derlying cau	use give	en in Part I		1 24a. Was auto perfo	Yes an 2	No 3 Pro	the cause of death?  obably 4 □ Unknown  opsy findings available ompletion of cause of  2 □ No
Vital	nysician; ine nis certificate Il director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital:	1  Inpatie	ent 2 🗆 ER/Qu	utpatient		Tothe	r: 4 🗀 Nu	`	-	dence 6X	Other (Specif	fy) HOSPICE
ision of	to use no sopplate of within a service is within 24 hours after death.  To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		Year) i	Time of injury arm, stree	М		at Yes 2 🗆	No	28d. Describe h			al Route Number,
Div	spiral or nours afte neral Dire y filled in		29a. Certifier 1 Certifying Physician: To	the best of r		death or	curred at th	ne time	, date and	place, ar	City or Tow		manner as sta	ated.
-	ithin 24 h	Medical	(Check 2 Medical Examiner; On the only one) 3 Certifying Nurse Practit	e basis of ex	amination and/o	or investig	gation, in my	opinio	n, death oc	curred at	the time, date a	and place, an the cause(s) a	d due to the cand manner as	ause(s) and manner stated s stated.
	- > - 0		30. Name and address of person who complete	cause of de	eath (Item 23a) (	(Type, Pr	'nt)	K	13	2)	72	9	5	2012
	Sta	e	TRACIE L. MORGAN, CR		300 DUL		VALL	EY	RD.	TIMO	NIUM, I	MD 210	93	
	Registra	ar	SEPUTZUIZ CENT	" J"	7									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A TW If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 219 38 1159 Director 1 X M 2 □ F 71 12/16/1940 Yrs Maryland Usual Residence of Deceden or 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 111 Cedar Hill Road 21225 should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed ar or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ethel Kletter Anthony Cadden 1 and 2 should be of Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 111 Cedar Hill Road Baltimore, Maryland 21225 Joan Cadden / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date permit, Page 1 s Department of H Important: If ite any injury or ot 1 Dunial 2 X Cremation 3 Removal from State Bayview Crematory or other pla 09/06/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway 23a part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case refe of to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

12-06611 Gerald Dondi Avo	n C	Please 1	<b>ype or P</b> State of I	rint in Black Maryland / De	Indelible !	<b>nk. Ensu</b> f Health ai	re All Copie	es Are Leg	jible.	2 2852
		- For State			ertificate o	f Death			g. No.	
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Wedical Examin		4a. Pacility Name (if not insti	tution, give stre	et and number)	Cratti		or Location of Death		4c. County of Dea	ath
		3800 West Belved				Baltimore		In Date of Bit	N/A	Pietralese (State or
Funeral Director	1	5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Ye  Months Da		_		eign Country) ////
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MD d 2 sho th and th and th and m 27 is		Elvina Hua	thes -1	mothaz	0b. Place of Dispo	Seagui	I Ave. 1	7) 10 M	20c. Location - City	or Town State
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Baltimore, permit. Pages 1 a. Department of He Important: If the injury or other to the the injury or other the	-	4 Donation 5 Other	er Specify:		1 1 22.	Name and Addre	ess of Facility	1100	UUIVIOVII	10/11/1)
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ox 68760, sath certificate be ex attending physician for use as the bunial.	sician/Medical	IF FEMALE:		3c. If yes, outcome of					23d. Date of deliv	rery
Box 68760, s death certificate by the attending physic for use as the business	an l	23b. Was decedent pregnan past 12 months?		Live birth	2 F	otal doddin	Ectopic pregn	ancy	Month	Day Year
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ion tendin eath.  tor: A the fur	텵	1 Natural 5 Accident	Pending Investigation	fd 9-1-12	fd 6:0		Yes 2 X No	unknown		
Division tal or Attendin rs after death. al Director: A led in by the fu	Certification:		Could not be determined	28e. Place of Injury -	At home, farm, str nd at ho	eet, factory, offic <b>ne</b>	e building, etc.	28f. Location (	Street and Number or State) 3800 Wes	Rural Route Number, City t Belvedere ltimore, MD.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil		4 Homicide 29a. Certifier 1 Certifyi	na Physician	To the hest of my know	wledge death occ	urred at the time	date and place, an	d due to the caus	se(s) and manner as s	stated.
o the B thin 24 o the F mplete	Medical	(Check only one) 1 Certifyi Certifyi 2 Medica	Examiner: On	the basis of examinati	on and/or investig	ation, in my opin	ion, death occurred	at the time, date	and place, and due to	the cause(s)
To with	Æ	29b. Signature and title of o		1 1-1			ense number		29d. Date signed (	
			411	11/			C.M.E. 		September 2,	
		30. Name and address of p	Frsion who comp Deputy Chi	pleted cause of death lef Medical Exam	(item 23a) iner 900 W.	Baltimore S	treet, Baltimore	e, MD 21223		

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 31 Day 201 Zear Physician/ Loretta R. Condon 6:45 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Sunrise Montgomery Village Montgomery Village 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 578-32-2718 Director 1 □ M 2 🗓 F September 26, 1920 Pennsylvania 91 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f shor any injury or other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 🔯 No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 11429 Schuylkill Road 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Senior Center Volunteer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Corder Charles V. Riffle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11429 Schuylkill Road, Rockville, Maryland 20852 Richard C. Condon Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept<sup>Date</sup>ber 1 X Burial 2 Cremation 3 Removal from State 2012 Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 21. Signature of Funeral Service Licensee Munistelle Dirant M01305 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Metastatic Melanoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 X No 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

To the I within 2

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suhair H. Abulfarag, M.D.

29a, Certifier

only one)

29b. Signature and title of certifier

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D31391

604 S. Frederick Avenue, #413, Gaithersburg, MD 20877

29d. Date signed (Month, Day, Year)

September 4,

2012

29c. License number

			Please Type or Print in Black State of Maryland /					-		_	gible.	
			1 = State State Registrar	Certificate			ila ivi	,	Reg. N	2 በ	12	28528
	Physicia	n/	Decedent's Name (First, Middle, Last)     PAUL CZERKOVICH					2. Date of De Month		ay	Year	3. Time of Death
~	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City,	Town, or	Location of	Death	9	4	,	of Death	12:45 am
			Franklin Square Hospital  5. Social Security Number 6. Sex / Age (In yrs. last bir	Ro	se	dal	e			Bal		ore
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last bir 1 Age (In yrs. last bir 216–12–8052  Usual Residence of Decedent	rthday) If Under Months Yrs.	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 10–1–1!	y, Year,	)	Cour	place (State or Foreign try) YLAND
	Maryland 28a-f sho otified at	Director	10a. State 10b. County 10c. City, Tow	PERRY	HALL						1	0d. Inside City Limits  1  Yes  No
	vith the 23a or st be n		10e. Street and Number	10f. Zip					10g. (		What Cour	itry?
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	9912 FOX HILL ROAD  11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Test (Sive)	13. Was Decede If Yes, speci	ent of His fy Cubar	, Mexican,					ce - Americ ck, White,	etc.
9-0	hours an atural	leted	3 Widowed 4 Divorced If res, give Year or Dates. 1943–1	945 a. Decedent's Usua	I Occupa	ition			16b.		usiness/In	HITE
21215-0036	within 72 /giene. <b>ner than "r</b> <b>t, the Med</b>	<b>Completed</b>	(Specify only highest grade completed)  Elementary (Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during most of working life. DO NOT use retired)						OTIV		
Maryland	id be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last)  ANDREW CZERKOVICH					First, Middle,		n Surnam	e)	
Mar	12 should lith and Me 27 is marl r traumati	P	19a. Informant's Name/Relationship (Type, Print)  DARIA MATEREWICZ  DTR.	b. Mailing Address					-			
	ye 1 and to the all the term 2 or other		20a. Method of Disposition 20b. Place of	4012 JAC of Disposition (Nam	e of		NO I	TINGHA			- City or To	
altimore,	Pag nen ant:		TE Buildi 2 E Cierration 5 E Hemova nom State	ery, crematory or ot TRINITY (	CEM.	9-	-5-20				E, MI	
Ball	permit. Departr Importa any inju		21. Signature of Fune al Service Licensee	22. Name and 9705 I				MUNEK OTTING				
	Physician  Medical Examiner  Be private transit  Be private transit tr	lical Examiner	shock, or heart failere. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or consequen	leura		eft	-us	ion				Interval Between Onset and Death
P.O. Box 68760	ne death certificate be executed the attending physician and ched for use as the burial-trans	Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Yo 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live Birth 2   Fetal death 2   Pregnant at time of death 3   Unknown	th 3  Ectopic p 5  Other (spe		/					ate of deliver	ery Day Year
ls, P.O	requires that the des been signed by the s should be detached i	ed by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying c	ause give	en in Part I.		23e. Did to		use cont		e cause of death?
<b>3ecorc</b>	The law require has been bage 2 shou	complete						24a. Was autor perfo			Were autoprior to codeath?	psy findings available mpletion of cause of
ta	ician: T	Be	25. Was case referred to medical examiner?		Otho	ce of Death	(Check o			10		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	cate: To	1 Yes 2 S No 1 I Inpatient 2 □ ER/O 27. Manner of Death 28a. Date of injury 28b.		c. Injury work?	at Nur	28	e 5 Resid d. Describe h				)
Divisio	al or Atter s after des il Director ed in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide 6 determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory,	office		28	3f. Location (S City or Tow			er or Rural	Route Number,
	he Hospit in 24 hour he Funere	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, only one) Certifying Nurse Practitioner: To the best of my knowledge.	or investigation, in m	y opinior	n, death occ	urred at th	ne time, date a	and place	e, and du	e to the ca	ise(s) and manner stated
	1 4		29b. Signature and title of certifier		License D64	number 485				ate signe	d (Month, i	Day, Year)
	15 t M		30. Name and address of person who completed cause of death (Item 23a) and Dr. Mustafa Filahussein 9000 31. Date filed (Month, Day, Year)  SEP 0 7 2012	(Type, Print) Franklin	Sq	uare	Dr	ive, Bo	a1+	ino	re, M	D 21237
	Stat Registra		SEP 0 7 2012 See 32. Registrar's Signature	Med								

DHMH 17 Rev 06-2011

12-06346	
Charles Canty	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

arles Canty		State of Maryland / Department of Certificate of Certificate		Mental Hy		201	2 28529
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)  Charles Canty			2. Date of Death Month August 22,	1	3. Time of Death 2005 hrs
edical Examir		erb	4b. City, Town, or Lo	ocation of Death	August 22,	4c. County of Dea	
		1725 North Carey Street	Baltimore	if Under 24Hrs.	R Date of Birt	N/A h(MM/DD/YYYY) 9. B	irtholace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  218-42-7972	Months Days	Hours Min.	07/25	Fore	ign country) MD
uny		Usual Residence of Decedent         10c. City, Town or Local           10a. State         10b. County         10c. City, Town or Local	tion				10d. Inside City Limits
Maryland 28a-f show any d at once.	5	MD N/A	Baltimo	re			1 XYes 2 No
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "matural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Director	10e Street and Number 1725 N. Carey St.	10f. Zip Code 21	217	10	og. Citizen of What Co USA	untry?
eath with items 23	Funeral		as Decedent of Hisp Yes, specify Cuban, I			White, etc.	erican Indian, Black,
after d	by F	3 Widowed 4 Divorced If Yes, Give Year 1 or Dates:	Yes 2X No		ork dono	Specify: B.	lack
2 hours	eted		nost of working life. I			TOD. TAING OF BUSINESS	""Haddiy
)036 within 7 iene. er than	Completed		arftsman	8.Mother's Name	(First Middle N	Hedwin (	Corp.
21215-0036 yill be filed within 7 I Mental Hygiene. I marked other than ic event, the Medical		17. Father's Name (First, Middle, Last) Edward Collins	10	Inez		alderi odiriame)	
MD 212 2 should b h and Meni 27 is marl umatic eve	10			and Number or R	ural Route Num	ber, City or Town, Sta	
md 2 sho lealth and tem 27 is traumati		20a. Method of Disposition 20b. Place of Dispo	sition (Name of ceme		Date	imore, MI	
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		1 Donation 2 Cremation 3 Removal from State crematory or or Cedar H	ill Cem.	09,	/01/12	Baltimo	ore ,MD
Saltir ermit. I epartm mporta	ı	21 Signature of Funeral Service Licens 22:	Name applied in the	of FBTYown	Jr. F	uneral Ho	ome PA
Physician	_	28a Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, s	such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
iMedical Examiner	0	failure. Ligionly one cause on each line.  Immediate Cause (Final disease a. Sharp Force Injuries					Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.					
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
cuted nnd transit	Examiner	(Disease or hijuly triat initiated events resulting in death) Last  Due to (or as a consequence of):					
an a	dical	UNPENDED AMENDED			-		
760, ficate be g physic the bur	/Mec	IF FEMALE: 23b. Was decedent pregnant in the 2	etal death 3	Ectopic pregnal	ncv	23d. Date of delive	ery Day Year
Box 68760 death certificate be attending physid for use as the bu	Physician/Me	past 12 months?  4 Pregnant at time of death 5 C	other (Specify)				
the part		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gi	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
s, P.O iires that t	ed by						robably 4 Unknown
cords law requi	Completed					esy prior to rmed? death?	
tal Rec cian: The certificate ector, page		25. Was case referred to medical	26 Place	of Death (Check of	1 Yes	2 No 1 V	Yes 2 No
Vita hysician this cer	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien				Residence 6 🗸 Ott	ner: Scene
n of ding Pl a. After funera		27. Manner of Death  1 Natural 5 Pending FOUND: 28a. Date of Injury FOUND: Day.Year) FOUND: PolyNear)	· · ·   · ·	y at Work? ′es 2 ✔ No		how injury occurred and stabbed	
Division of Vital Records, tale Attending Physician: The law requirers after death.  al Director After this certificate has been siled it by the funeral director, page 2 should be it by the funeral director, page 2 should	Certification:	2 Accident Investigation Aug 22, 2012 1950 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office bu	uilding, etc.	or Town S	itate)	Rural Route Number, City
Division To the Hospital of Attention within 24 hours after death To the Funeral Director		4 V Homicide determined (Specify) Townhouse / Rowhouse 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur		boo seele boo see	1725 North C	arey St., Baltimore,	
To the Hos within 24 hu To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, dearn occion of the property of the pasts of examination and/or investigenty one) 2 Medical Examiner: On the basis of examination and/or investigenty of the property of the past of	ation, in my opinion,	, death occurred a	t the time, date	and place, and due to	the cause(s)
E ≥ E 8	Me	29b. Monature and title of certifier	29c. License			29d. Date signed (A August 23, 201	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.N	¥1. L.		/ tugust 20, 20	
		Laron Locke MD. Assistant Medical Examiner 900 W. E	Baltimore Street	t, Baltimore, N	MD 21223		
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 0 7 2012 32. Legistrar's Signature	100				
DHMH 17 Rev 1/2		OCME <b>ORIGIN</b> .	AL				

DHMH 17 Rev 1/2001 OCME 2006

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Estelle D. Constantine Medical 4a. Facility Name (if not institution. County of Death Examiner SAINT SOSE 50 ALTIMO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 218-07-1010 Director 1 M 2 X F 92 Maryland Feb 24, 1920 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Nexton Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Timonium MD. Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12340 Rosslare Ridge Road #204 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pavleros Alexander Dezes Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Constantine/ Daughter 12102 Cullane Ct. Timonium, MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greek Ortho. Cem. 9-8-12 Woodlawn, MD. 4 Donation 5 Other (Specify) <sup>22. Name and Address of Facility</sup> on Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physician: The lew requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has d in by the funeral director, page 2. autopsy perform 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No |은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aff

To the Funeral Di

completely filled in Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated erything Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year) OSLER DRIVE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brian William Casper State of Maryland / Department of Health and Mental Hygiene 2012 28531 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1105 hrs Medical Examiner September 2, 2012 Brian William Casper 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Worcester 105 123rd Street Ocean City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreian Months Days Hours Director country) Maryland 1967 1 X M 2 F Oct. 24, 213**-**02-4094 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Parkton Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 듑 10 Apple Valley Court USA 21120 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 A Married 1 Never Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: white Specify: <u></u> or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygiene. 27 is marked other than "r matic event, the Medical E Baltimore, MD 21215-0036 12 Chef Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Roger W. Casper Doris M. Marsh 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather R. Casper of Health an wife 10 Apple Valley Ct.; Parkton, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 9/7/2012 Towson, MD 4 Donation 5 Other Specify 21. Signature of F in ral Service Lige. 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home. Towson, MD 21204 Inc. Approximate Interval 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical aOxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. and Physician/Medical AMENDED 23a,27,28a-f,per me,g931 9-11-12 sm signed by the attending physician abe detached for use as the burial -**▼** UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Day Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 쥳 1 Yes 2 No 3 Probably 4 V Unknown Completed has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other<sub>4</sub> Nursing Home 5 Residence 6 **O**ther: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural unknown 5 Pending 1 Yes 2 X No fd 9-2-12 fd 11:05 am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 105 123rd St. Ocean City, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be To the Hospital within 24 hours a To the Funeral I Townhouse/Rowhouse determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. September 3, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol H. Allan, MD 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	_ State	f Maryland / De	partment of F e <i>rtificate of L</i>		vientai Hyg	eg. No. 201	2 28532	
			Registrar  1. Decedent's Name (First, Middle, Last)	th	3. Time of Death					
	Physicia Medic		Carl Solomon Carls		September 5 2012 4:30p M					
	Examin	er	4a. Facility Name (if not institution, give street and num 939 Hoods Mill Road	ber)	4b. City, Town, or Woodt	Location of Death		4c. County of [Carro]	Death L1	
	Funeral Director		5. Social Security Number 219–22–8727  Usual Residence of Decedent	7. Age (In yrs. last birthday 85 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 29	Year) 9.	Birthplace (State or Foreign Country) MD	
	ryland -f show ied at	Director	10a. State 10b. County MD Carrol1	10c. City, Town or Woodbi					10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	a or 28e be notif	al Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha		
	ath witl ems 23 must	Funeral	939 Hoods Mill Road  11. Marital Status 12. Was Dece	dent Ever in U.S.	21797  3. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		American Indian,	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marita Otatus	rces? 2 No WWII	If Yes, specify Cuba 1 ☐ Yes 2 🔏 No	an, Mexican, Puerto	Rican, etc.)		White, etc.	
15-0	72 houi "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16b. Kind of Business/Ind							
21215-0036	within giene. er thar		Elementary/Secondary (0-12) College (1-	-4 or 5+)	eneral cor			contrac	cting 	
Maryland	d be filed Mental Hy srked oth	To Be	17. Father's Name (First, Middle, Last)  Oscar Carlson  18. Mother's Name (First, Middle, Maiden Surname)  Arlene Fleming							
Man	12 should lith and Market 127 is market reauma		19a. Informant's Name/Relationship (Type, Print) Mrs. Betty Carlson (spou		ailing Address (Street Hoods Mill				e, Zip Code)	
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition  1. X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State cemetery, c	sposition (Name of trematory or other place)	i	Date	20c. Location - Cit Sykesvil		
Baltin	permit. P Departm Importar any injur	100	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Haight Funeral Home & C P.O. Box 195 Sykesville, MD 21784							
			23a. Part 1. Enter the disease, or complications that one shock, or heart failure. List only one cause on earths.	caused the death. Do not each line.	enter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician Medical	ő l	Immediate Cause (Final disease or condition resulting in death)	(or as a onsequent of):	14	.^ >			Onset and Death	
	Examiner	er	Sequentially list conditions, b.	Par Fr	msms	1013	ease		years	
	uted d ansit	amin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):						
0	be exec sician an burial-tı	edical Examiner	resulting in death) Last Due to	(or as a consequence of):						
68760	tificate ng phys as the		IF FEMALE:							
Box 6	res that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?		3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date o		
, P.O.	es that the signed by I be detac	by Ph	Part II. Other significant conditions contributing to a	leath but not resulting in the	ne underlying cause gi	iven in Part I.	23e. Did to	1	ute to the cause of death?	
ords	requi	pletec	1 4 0 3 3 -1 1				24a. Was a	an 24b. Wei	re autopsy findings available or to completion of cause of	
Rec	The lav	Com					perfor	rmed? dea	tth? Yes 2 No	
ital	sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	Inpatient 2 ER/Outpa	Oth	Place of Death (Chener: 4  Nursing H	\	lence 6 Other	Specific	
of V	ng Phy: fter this ineral d	ate: To	27. Manner of Death 28a. Date		e of 28c. Injury wor	ry at k?		ow injury occurred	Specify	
ion		Investigation   Suicide   Suicide							or Rural Route Number,	
S	Attendil r death. ector: Ai by the fu	rtific	3 Suicide 6 Could not be 28e. Place		street, factory, office					
Division of Vital Records,	ital or Attendi urs after death. iral Director, A illed in by the fu	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place build	ing, etc. (Specify)		and the second selection	City or Tow		as stated	
Divis	ie Hospital or Attendi n 24 hours after death. ie Funeral Director; A pletely filled in by the fo	Medical Certific	3 Suicide 6 Could not be determined 28e. Place build	ing, etc. (Specify)  Dest of my knowledge, dealess of examination and/or in	ath occurred at the tim	ion, death occurred	and due to the ca	ause(s) and manner	the cause(s) and manner stated.	
Divis	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certific	3 Suicide 4 Homicide  28e. Place build  29a. Certifier (Check only one)  29b. Signature and title of certifier  3 Cortifier Certifying Physician: To the ba Certifying Nurse Practitione	ing, etc. (Specify)  best of my knowledge, deals is of examination and/or in r. To the best of my knowled	ath occurred at the tim vestigation, in my opin dge, death occurred at 29c. Licens	ion, death occurred the time, date and se number	and due to the ca at the time, date a place, and due to the	ause(s) and manner nd place, and due to he cause(s) and mar 29d. Date signed (f	o the cause(s) and manner stated.  Iner as stated.  Month (Day, Year)	
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Certific	3 Suicide 4 Homicide  28e. Place build  29a. Certifier (Check only one)  29b. Signature and title of certifier  3 Cortifier Certifying Physician: To the ba Certifying Nurse Practitione	ing, etc. (Specify)  Dest of my knowledge, dealess of examination and/or in	ath occurred at the tim vestigation, in my opin dge, death occurred at 29c. Licens	ion, death occurred the time, date and se number	and due to the ca at the time, date a place, and due to the	ause(s) and manner nd place, and due to he cause(s) and mar 29d. Date signed (f	o the cause(s) and manner stated.  Iner as stated.  Month (Day, Year)	

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 30,2012 FRESOLINA ESPINAL COLLADO 10:14a M Medical **Examiner** 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 3511 E. FAYETTE STREET BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 214-85-0061 DOMINICAN Director 1 🗆 M 2 🔀 F 80 09/10/1931 Usual Residence of Dec REPUBLIC show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Xyes 2 No MD N/A BALTIMORE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a **Funeral** 3511 E. FAYETTE STREET 21224 DOMINICAN REPUBLIC items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Spec#OMINICAN "natural" Completed Specify 3 X Widowed 4 Divorced WHITE Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 8 HOUSEWIFE DOMESTIC event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be a Department of Health and Mental Important; If item 27 is many injury or othorone. ರ SANTIAGO **ESPINAL** LIDIA COLLADO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSE MELO/SON-IN-LAW 3515 E. FAYETTE STREET, BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation TRINITY CEMETERY 4 Donation 5 Other 9/1/2012 BALTIMORE, MARYLAND Signature of F Try Address ZETTER INC. FUNERAL HOME 1 EASTERN AVENUE, BALTO., MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ d disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence oil burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the at Id be detached for 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 : has autopsy performed Yes 2 death? ☐ Yes 2 ☐ No al or Attending Physician: a fer death.

Director, After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29c. License number completed cause of death (Item 23a) (Type, Print) Salome Hawkins 30. Name and address of person who & Rolling Crossroads Hearnand Hospice, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28534 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 19:56 M Raymond Bernard Connolly Jr. 2012 ep tember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 017-24-3939 1X M 2 □ F 79 Feb. 25, 1933 Massachusetts 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Harford 1 Yes 2 No Joppa the 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? must be Funeral 23a 825 Woodmont Court 21085 USA iral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2X Married Completed by 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify. White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Weapon Specialist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Bernard Connolly Sr. Rebecca (unk) Blanc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Marian Connolly / Wife</u> 825 Woodmont Court, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-10-2012 Fallston, Maryland Highview Memorial Gdn 22. Name and Address of Facility McComas Funeral Home, P.A. WYnas 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the viscase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 900 d disease or condition resulting in death) oda4 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year ed by the a detached f 9 I Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Raymond of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ER/Outpatient 3 DOA Inpatient 2 Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Connolly Division of Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fi Aecident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature as 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

ionth, Day, Year)

21014

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ Year Billie Sue Dorsey O 4 1:40 aLM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEDICAL ROSEDALE BALTIMORE SQUARE FRANKLIN CENTER Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) **Director** 1 🗆 M 2 😾 F 233-46-5859 80 June 10,1932 West Virginia Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Page 1 and 2 should be filed within 72 hours aner death the stand Mental Hygiene. That: If item 27 is marked other than "natural", or items 23a or 28a-f sliury or other traumatic event, the Medical Examiner must be notified: MD Baltimore Rosedale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4914 Brightleaf Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No 1 Yes 2x No Specify 3 🗌 Widowed 4 🔲 Divorced Specify. Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jack Spence Florence Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4914 Brightleaf Court Rosedale, Maryland 21237 Mr. Heber D. Dorsey (Husband) Department of Heali Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖔 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place 9/7/2012 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns Middle River, MD Signature of Funeral Service Licensee Justin Jones Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave, Dundalk, Maryland a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗶 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider iniury 5 Pending work? 1 Yes 2 No

burial-transit and physician that the death certificate be Division of Vital Records, P.O. Box 68760 the attending plant for use as as signed by t d be detach has After this certificate Physician: director, funeral ( Certificate: To the Hospital or Attending death. within 24 hours after deat To the Funeral Director: filled in by

show

レルタピア, ドルル Baltimore, Maryland 21215-0036

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29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier HOSDIT2137

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANGRAMPURKAR SQ. HOSPITAL, BALTIMORE FRANKLIN

State Registrar

Medical

Accident Suicide

31. Date filed (Month, Day, Year) SEP 0 7 201 32. Registrar's Signature

Investigation

determined

6 Could not be

01

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michele Phyllis Davenport August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Prince George's Hospital Regional dure Laure 5. Social Security Numberunk 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours Director 1 M 2 X F 63 1949 New Jersey March 31, ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location unk 10b. County unk 10a. State 10d. Inside City Limits Director unk 1 🗆 Yes 2 🗆 No MD 10f. Zip Code unk 10e. Street and Number unk 10g. Citizen of What Country? Funeral USA . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. "natural", or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry should be filed witten....h and Mental Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard V. Davenport Mary Ann Squitieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14132 Spotswood Dr; Ruckersville, VA 22968 Helen Ferro - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place. 4 □ Donation 5 to Other (Specify) in state Signature of Funeral S rvice License d S Wade 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Advanced Small Cell Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner neumonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Pulmonary attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Embolism that the death certificate be executed Venous Physician/Medical Thrombosis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death ed by the a 9 Unknown Unknown P.O. signed to d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Difficille Colitis Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred eral Director: After I filled in by the funer To the Hospital or Attending Natural 5 Pending iniury 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8:49 PM

Interval Between

Onset and Death

State Registrar 29b. Signature and title of certifier

George I. 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKang, MD

DHMH 17 Rev 06-2011

Laurel Regional Hospital

D41248

7300

Van

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LOUISE 0501AM WILLAMS IXON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 111 50 CM BARAMON MANY LAWS JNIU BUSIN UF If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) 239-26-4348 **Director** 1 🗆 M 2 🔀 F 92 3-24-1920 NC Usual Residence of Decedent 28a-f show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Completed by Funeral 23a within 72 hours after death with 815 Winters Lane Apt. 319 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, event, the Medical Examiner Armed Forces? . or Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specif African-American Yes. Give "natural", 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Domestic ould be filed v nd Mental Hyg marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic Robert Williams Anna Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Jones/ Granddaughter 3306 Southgreen Road, Baltimore, MD 21244 20a. Method of Disposition
1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other place) Metro Cramatory 9-6-2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wile Fineral Home P.A. of Palto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMBOLLS M Physician/ PURMON AM Medical resulting in death) **Examiner** OMPLI CATIONS MATTINE Esquer tially liet our ditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last SEPSIS and CERTIFICA Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DECUBINS Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Fritzerole 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsv performed? ✓es 2 □ No certificate 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 
Natural 5 Pending within 24 hours fter death.

To the Funeral Director Af completely filled in by the fu 1 Yes 2 Accident July 01, 2013 UNE 2 X No Investigation SLIP ON 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)
1613 Eutaw Place Apt 201 Home To the Hospital Medical Comitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Planminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Planminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Planminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only on 29b. Signature and title of ce 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARMUL MA 21201 MicHARL GREENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011 OCME

Funeral Director

To Be Completed by Funeral Director	Medical Certificate: To Be Completed by Physician/Medical Examiner	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	hu
Baltimore, Maryland 21215-0036	Division of Vital Records, P.O. Box 68760	
JOAN DOWNS CHOSICAIS 0170		•

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		Registrar  1. Decedent's Nam	o (First Middle I	oot)		Cer	tificate of D	)eath		Reg. No.	112	285	39		
Physicia Medic			izabeth I	,					2. Date of Dea Month Sept.	Day	Year 2012	3. Time of Dea			
Examin	er		fnot institution, gi odside Av	ve street and number) venue			4b. City, Town, or Haletho		•	4c. Count Balt	y of Death Lmore				
Funeral Director		5. Social Security N 212-32-86		Sex 7. Ag	e (In yrs. las: 75	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Nov 28	, Year) 3, 1936	9. Birthp Coun MD	place (State or For try)	reign		
f show ed at	ctor	Usual Residence of 10a. State	f Decedent 10b. County		10c. City,	Town or Loc	eation				1	0d. Inside City Lir			
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is 23 nust	Jera	1916 Woo	odside A	venue	21227			USA							
Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show up vinury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Mari 3 ☑ Widowed	ried 2  Married	12. Was Decedent Armed Forces? 1			Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🔀 No	spanic Origin? (Spen, Mexican, Puerto Page Specify:	cify Yes or No- Rican, etc.)		ck, White, e	American Indian, Vhite, etc. White			
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Mental H arked otl atic even	To Be	17. Father's Name		")				18. Mother's Name Rober	(First, Middle, I cta Herr		e)				
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when the found are beauther this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months? No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day Year									
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te has beer age 2 shou	Completed	Canc	me ma	e of Ba	east	t	24a. Was an autopsy performed?  1 Yes 2 No 3 Proba  24a. Was an autopsy prior to competence death?  1 Yes 2 No 1 Yes 2								
certifica irector, p	æ	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:			Other	ce of Death (Check	only one)		1  Yes	-			
After this funeral d	ate: To	27. Manner of Deatl	h 5 🗌 Pending	28a. Date of inju (Month, Day		Bb. Time of injury	28c. Injury work?	·	ne 54V Reside 8d. Describe ho						
Director: d in by the	Certificate	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigati 6  Could not determine	be 200 Place of Init		e, farm, stre		/es 2 □ No 2	28f. Location (St City or Town		reet and Number or Rural Route Number, , State)				
ne Funera pleted fille	Medical	(Check 2	Medical Exar	ysician: To the best of niner: On the basis of e irse Practioner: To the	xamination ar	nd/or investi	nation, in my opinior	death occurred at t	the time date an	d place, and du	e to the cau	se(s) and manner s	stated.		
Tota	-	29b. Signature and	title of certifier	cold an	whe		29c. License			29d. Date signe					
		30. Name and addre	ess of person who	completed cause of d	ath (Item 2	3a) (Type, Pr		Lytheru	ا ا ص () زر	Mdo	109	3			
Stat Registra	e	31. Date filed (Mont	P 0 7 20	2 Server	r's Signature	par	4	-91-0010	1.161	10 2	101				
7 Pay 7/20					- 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Jamar tan Saltmore City Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 216-80-4140 52 Maryland 06/25/4960 Director 1 M 2 □ F Yrs. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct Maryland N/A 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 818 N. Collington Avenue 21205 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give SpecifyAfrican American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 hand Mental Hygiene.
7 Is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Improvement Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roderick J. Dorsey Mary Inez Stokes 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tameaka Dorsey-Johnson / daughter 1154 Sargeant Ct. Baltimore, injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 09/06/2012 Glen Burnie, Maryland Signature of Funeral Ser 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ 7554 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HOUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical use as the attending p for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe 2 deNo Yes 201 1 Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Ves မ 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending nours after death.

Teral Director: After the function of the 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and the 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 Lock Laven blug (1 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 26 Medical UNATO 2012 2030 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8392 Fordham Court Union Bridge Frederick **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 218-56-7509 1 M 2X F 63 Yrs 25,1949 Mar. Washington, DC Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick Union Bridge 1 ☐ Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8392 Fordham Court 21791 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 No ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Research Data Process Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: if item 27 is marke any Injury or other traumatic v Walter Albert Schultz Ione Heimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8392 Fordham Court Union Bridge, MD 21791 Peter Dunnigan / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 8/29/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Coing Home Cremation Service, P.O. Box 784

Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Mestastetic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Yes Division of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 2 No Other: 1 Tes |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigating in morning the property of the property of the page of examination and/or investigating in morning. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD060335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #327 18111 Prince Philip MD

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year) SEP 0 7

Olney

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Kenneth Dunn		1- For State Registrar		artment of H rtificate of D		vientai Hy	Re	g. No.	2 2854
Physicia Medical Examir		Decedent's Name (First, Middle, I Kenneth Dunn	Last)				2. Date of Death Month September		3. Time of Death 2015 hrs
		4a. Facility Name (if not institution, 929 North Hill Road	give street and number)		city, Town, or Local	ation of Death	<u> </u>	4c. County of Death	
Funeral Director		unk	Sex 7. Age (In yrs. 48	last birthday) If N		f Under 24Hrs. Hours Min.	<b>-</b>	h (MM/DD/YYYY) 9. Bir 64 Foreig	
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent  10a. State MD  10b. County N / A		Town or Location					10d. Inside City Limits 1 Yes 2 No
the Maryl a or 28a-1	Director	10e. Street and Number 929 North Hil	l Rd	10	f. Zip Code 21218		10	og. Citizen of What Cour USA	ntry?
	by Funeral		1 Yes 2 No	If Yes, s	ecedent of Hispan specify Cuban, Me	exican, Puerto pecify:	Rican, etc.)	ATTICE ATTICE AME Specify:	er.
036 tithin 72 hour ene. r than "natu	Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's U during most o Ven	of working life. DO			16b. Kind of Business/I	•
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica	B	17. Father's Name (First, Middle, La Thjmas Dunn Thomas Dunn	- Central 20 20 20 20 20 20 20 20 20 20 20 20 20		Ja	anie D	unn	laiden Surname)	
MD 2 d 2 should lth and M n 27 is m numatice	2	19a Informant's Name/Relationship JacqueLine SI						ber City or Zoyn 2506 MD 206	
Baltimore, MI permit. Pages I and 2 & Department of Health a Important: If item 27		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spec	3 Removal from State Ba	Place of Disposition crematory or other payView C	remator	y 9/7		20c. Location - City or Balt., MD	
Balti permit. Departri Import injury		21. Signature of Funer Service I						lose F.Sv MD 21206-	5105
Physician /Medical Examiner		23a. Par I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)		ocaine In			respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
and M.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of						
uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of	of).	-				
60, tte be executed hysician and e burial - transit	Medical	X UNPENDED	AMENDED 23a,27,	_	me,g931	9–20–	12 sm		
cath certifice at the for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of pres 1 Live birth 4 Pregnant at time of de	2 Fetal de	eath 3 E	Ectopic pregna	ncy	23d. Date of delivery Month D	day Year
P.O. B	≥∣	Part II. Other significant condition	ns contributing to death but not	resulting in the under	lying cause given	in Part 1.		pacco use contribute to	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2.	Completed						24a. Was a autops perforr	y prior to c ned? death?	topsy findings available ompletion of cause of s
Vital Rec ysician: The his certificate director, page	B	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	26 Place of D	eath (Check of		Residence 6 🗸 Other	Scene
n of V	입	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury		Work?	28d. Describe h	ow injury occurred	
Sion Attend r death. ector: by the f	catio	2 Accident Investig	ation 28e Place of Injury - At h	unknown	1Yes		unknowi 28f. Location (Si	nt treet and Number or Ru	ral Route Number, City
Divis	Certification:	3 Suicide 6 X Could n  4 Homicide determi	found	at home			or Town, St. Baltimo	ate) 929 North	Hill Rd.
To the Howithin 24 h	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	dge, death occurred a and/or investigation, i	at the time, date a in my opinion, dea	nd place, and ath occurred at	due to the cause t the time, date a	e(s) and manner as state and place, and due to the	ed. e cause(s)
H % H %	ž	29b. Signature and title of certifier	n nt		29c. License nu O.C.M.E			29d. Date signed (Mor September 3, 20	
Strafe	-	30. Name and address of person where the control of		•	imara Ct	Daltim	MD 24222		
Sta	-	Jack Titus MD. / Deput 31. Date filed (Month, Day, Year)	y Chief Medical Examine 32. Registrar's Signat		imore Street,	paitimore,	IVID 21223	-	-
Registr	rar	CED 0 7 2012	Centra B. A.	par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 2012 ROBERT FADES 08:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE, MD GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 217-40-704 Country) Director 1 X M 2 □ F 68 1944 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or iteme many injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Himore 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 ☐ No Yes, Give 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Exterminator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Andress (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)

On Site Chematics 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, 4 ☐ Donation 5/1☐ Other (Specify) 21. Signature of Fune al Service Licensee March FIH-East 110 North Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysiciani Ventricula disease or condition resulting in death) minutes Medical Due to (or as a consequence of): Examiner Lvemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): End-Stage attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed years that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day detached q ☐ Unknown g 🗌 Unknown Division of Vital Records, P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?/ 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No Congestive heart failure has After this certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🖄 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P27613 eptember 5,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RISHIKESH DALAL MD 5601 Loch Raven Blud

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

39. Registrar's Signature

Baltimore, MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# / SperFH, G931, 977/2012, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 2012 4:05 4, DAVID **ECKSTUT** Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1934 Hours Min **Director** 179-26-8235 1**X** M 2 □ F <del>78</del> 77 Yrs. 10/16/1933PAUsual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Oa. State Director must be notified 1 Yes 2 X No MD MONTGOMERY POTOMAC Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 11720 AMBLESIDE DRIVE 20854 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify. 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 ANALYST DEFENSE DEPARTMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o 2 BERYL **ECKSTUT** MOLLY COOPERSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 11720 AMBLESIDE DRIVE, POTOMAC, MD ERICA ECKSTUT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH ISRAEL CEMETERY 09/05/2012 WOODBRIDGE, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ACUTE MYELOID LEUKEMIA Medical resulting in death) Due to (or as a consequence of) **Examiner** ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last SUBDURAL HEMATOMA and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Month Day Year Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No Hospital or Attending Physician: The 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1X Inpatient 2 - ER/Outpatient 3 - DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Injury at work? 28c 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 66264

DHMH 17 Rev 06-2011

State Registrar

ORIGINAL

8600 OLD GEORGETOWN ROAD, BETHESDA, MD

20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BABAK PIROUZ, M.D.,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHER Physician/ SEPTEMBER 3 2012 06:25A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death EMERITUS OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 215-12-7688 Director 1 X M 2 □ F 92 12/21/1919 MD and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE 1 Yes 2 K No PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1840 REISTERSTOWN ROAD, #233 21208 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 2 No X Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: 3 X Widowed 4 Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the STOCKBROKER LEGG MASON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic eve မ SAMUEL FISHER CARLYN STERN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a SAMUEL FISHER/SON 2350 MONTEVALLO ROAD, #1406, BIRMINGHAM, AL 35223 Department of Health
Important: If item 2:
any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HAR SINAI CONG. 09/06/2012 OWINGS MILLS, MD 21. Signature of Euneral 8 Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysicianz Onset and Death disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 9 Unknown Pregnant at time of death Month Day Year **₹**No the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be men 2 / No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 🗆 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 4 Homicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

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certifie

32. Registra

29b. Signature and title o

DHMH 17 Rev 06-2011

29c. License number

Court Roge

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29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Q McArthur Fields 2 0 1 2 1:02 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A 2211 Aiken St. Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 217-40-9880 Director 1 X M 2 . F 69 2/19/1943 VA Usual Residence of Decedent 2 should be filed within 72 hours after death with the Merylend th and Mentel Hyglene. 27 is merked other than "natural", or Itema 23a or 28a-f show treumette event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2211 Aiken St. 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th <u>Van Driver</u> N/A Omni Eye Service Be 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Sumame) 2 Fannie Mae Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Depertment of Heaith a Importent: If Item 27 is any injury or other tree Jannie Fields-Wife Aiken St. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, MD 9/8/2012 Cemt. 21. Signature of Fluneral Service Licensee 22. Name and Address of Facility March F/H-East North Ave. Baltimore, MD 21202 1101 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 Grh. muss disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 DA Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 No ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of pertifier 29c. License number 346 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3312 St # 136 BATIMIRE, MARYLAND 21218 MD 200 E 31. Date filed (Month, Day, Year) SEP 0 7 2012 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Fuller Ruth 2012 5:55 A Sept Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health & Rehab. Center Bethesda Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 026-26-0645 **Director** 1 🗆 M 2 💢 F 77 Jan. 24, 1935 Massachusetts 28a-f show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Montgomery Rockville 1 Yes XX No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10814 Antiqua Terrace #102 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black. White, etc. ş 1 X Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. Elementary/Secondary (0-12) 1.2 College (1-4 or 5+) Secretary, Admin Manager Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fuller E11a Wood Harry Maeder Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is Marjorie D. Fuller / Sister 10814 Antiqua Terr. #102, Rockville, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State Uniformed Sers. Univ. 09/05/2012 4X Donation 5 ☐ Other (Specify) Bethesda, MD 21. Signature of Fundal Se Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 933 Gist Ave., Silver Spring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exe physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: ase ves, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months?

1 Yes 2 No
9 Unknowh Pregnant at time of death Month Day Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 2 N director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 PNo Other မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? s after death. Accident 2 🗌 No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

10

DHMH 17 Rev 06-2011

Registrar

10110 MOLECULAR DR. #206, ROCKVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TROUNG BAO M.D.,

SEP 0 7 2012

20057124

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical trase 1 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death ALTIMOR MEDICAL TOWSON Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Days Hours (Month, Day, Year) Director 1 M 2 | F 506-44-3687 Jan 14, 1940 Nebraska octant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, The Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Talbott Avenue 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Divorced 4 Divorced Year or Dates. 1958 - 59 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked others any injury or other. Elementary/Secondary (0-12) College (1-4 or 5+) Mental Health Family Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl L. Fraser Ruth Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jiawan Huang Fraser /Wife Talbott Avenue Lutherville Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Sep 07 Beltsville, Maryland Chesapeake Crematory 2012 21. Signature of Funeral Service License Mol555 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran ate has been signed by the attending physician and page 2 should be detached for use as the burlal-trai Due to (or as a consequence of): ior Attending Physician: The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certifical completely filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔊 No Certificate: To 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Pragationer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier otem 2012 erson who completed cause of death (Item 23a) (Type, Print) TABASSI M.D TOW SOM 160 Date filed (Month, Day, Year) 2012 Registrar

FOSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 O & Physician/ 42 AINE FRIA ZIER 30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SILVER SPRING CROSS HOSPITAL MONTGONER 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk Hours 9567 Director 578-56-1 □ M 2 🗹 F 08 show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD MONTCOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20904 USA 13906 CASTLE 12. Was Decedent Ever in U.S. Armed Forces? unk 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No Specify: If Yes, Give "natural" 3 Divorced 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation **u** 1 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) be filed within unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra HOLY CIROSS HOSPITAL FOREST 002 613 RI UEIR SPRING MD 20910 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signaturo Euneral Servici Licensee 22. Name and Address of Facility State Anatomy Board Wald Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Inter the disease, or c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or a art failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARDIONYOPATH Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit SEVERE that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atter d be detached for u in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? Yes 2 No 2 🗆 No 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 욘 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completely filled in by the 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 608 30. Name and address of person who completed cause of death ( 23a) (Type, Print) MD FOREST GLEN 25 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 02 2012 Physician/ Harry Milton Fridley IV 6:00 aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery National Institutes of Health If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours March I 1 🕅 M 2 🗆 F 215-46-0516 Washington, D.C. Director 67 1945 l Usual Residence of Decedent Department of Health and Mental Hygiene. In portant. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8428 Fox Run 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Distributor Turf Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Milton Fridley III Jane Ellen High 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8428 Fox Run, Potomac, Maryland 20854 Susan Felts Fridley/Wife 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) September Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 6, 2012 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funefal Service Licenses ettel 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ MONTH METASTATIC NONSMALL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine If any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completed filled in by 1 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature at

JAN DAVIOSE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

10 Center Drive, Bethesda, MD 20892

29d. Date signed (Month, Day, Year)

3.2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 2012<sup>x</sup> Virginia A. Floyd 0135 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Friends Nursing Home Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Director 149-07-5706 1 □ M 2 🖺 F 92 Maryland Nov. 17,1919 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20860 17401 Ouaker Lane Room 222B Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3

Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Counselor State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Hamke William Hossfield thent of Health and Mertant of Health and Mertant. If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17320 Quaker Lane B24 Sandy Spring, MD 20860 Priscilla Sabino/daughter Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 9/10/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signatur Africa Service Licensee <sup>22</sup> Name and Address of Eacility
Going Home Cremation Service, P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville,MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consuluence of for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Yea 5 Other (specify) Pregnant at time of death been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🛂 Unknown Completed Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 - Residence 6 - Other (Specify) 1 Tes 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3  $\square$  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier DDO 69829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTGOMERY VILLAGE drive Office rank

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. Physician/ 2012 3, 8:10 p. M Green lhomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7716 Tomlinson Avenue Cabin John Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Days Hours (Month, Day, Year) Country) New Jersey 213-40-9202 70 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 ☐ Yes 2 🕅 No MD Montgomery Cabin John 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20818 United States 7716 Tomlinson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🄀 No "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Artist Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Dorothy Cake Thomas Patrick Green, Sr. . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7716 Tomlinson Ave. Cabin John, Maryland 20818 Linda J. Green (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a Method of Disposition Sept Date 06 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 K Cremation 3 Removal from State Beltsville, MD. 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Rapp Funeral & Cremation Service 21. Signature of Funeral M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
14 months Immediate Cause (Final Physician/ disease or condition Acute Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner ALS (Lou Gehrig's Disease) 14 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been simmed to the contribution of the funeral Director. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred s after deu ral Director: Afte rv the fr 5 Pending injury Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 👺 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month. Day, Year) 09/05/2012 MD035742-DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year SEP 0 7 2012

Elham Bayat, M.D. 2150 Pennsylvania Ave., N.W., Washington, DC 20037

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1&23e per PHY G932 10/31/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28554 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:40PM Physician/ Month Fannetta P. Gray 2012 Medical give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genera olumina HOSMA HOWA If Under 1 Year If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign Funeral Days Months 1 M 2 W Hours Min. 3 (Mon Day, 1973 Country) **Director** Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State ity, Town or Location 10d. Inside City Limits Director C 1 Yes 2 No hlano lumbia 10e. Street and Number Unit 10f. Zip Code 10g. Citizen of What Country? 29204 Funeral 825 ace, 6. within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Blac If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. NO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ncipa Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur မ arris ovenr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Informant's Name/Relationship (Type P) Cunghter City or Town, State, ₹ip Code) olumbia oral 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 5151 Balto. Nat'l 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final > 4 an Peath Physiciani disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Exami ending physician and use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year signed by the ard be detached for 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> DIFFICILE WITIS Division of Vital Records, 2XXNo 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6399 SEPT. 5, 2012 51 of berson who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 3155 EHELM! 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Month Richard J. Gordon 2012 September 7:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min 042-16-5456 Director 1 🕅 M 2 🗆 F 91 September 21, 1920 Massachusetts Usual Residence of Decedent 28e-f shov 10a. State 10b. County or then "naturel", or items 23e or 28e-f sho the Wedical Evarainer must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Montgomery Darnestown 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? era 14900 Kelley Farm Drive 20874 United States death F 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced WWII Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry . If item 27 is merked other then "n. or other traumatic event" (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Foreign Service Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Maxwell Gordon Rose Beck 1 end 2 should be of Health and Me item 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Henderson /Daughter 14900 Kelley Farm Drive, Darnestown, Maryland 20874 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Unk Date 20c. Location - City or Town, State Department of I Importent: If its eny injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemeter Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Makelle Brand M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Complications of Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): -€xaminer Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami or Attending Physicien: The lew requires that the death certificate be executed signed by the ettending physiclan and d be detached for use as the burial-transit Parkinson's Disease that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Neuro Degenerative Disease Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 \_ Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dementia, Bladder Cancer, Colon Cancer Records, 1 Tes 2 No 3 Probably 4 1 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No director, **Division of Vital** 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 2 🕅 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fur 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

Registrar's Signatu

Bindu Joseph, M.D.

31. Date filed (Month, Day, Year).

29c. License number

D0060634

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

September 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19a per fh, 932 10-17-12 sm.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 donth 30 ay Edgar P. Green 2012 10:09A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice N/A Baltimore 5. Social Security Number 215 – 28 – 3699 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours **Director** 1X□ M 2 □ F 79 02/25/1933 Maryland or then "neturel", or items 23a or 28a-f show the Wedcal Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours efter death with the Maryland 10d. Inside City Limits Director MD N/A Baltimore M Yes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 827 Arlington Ave. 21217 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+) Dry Cleaning A/NBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mentel F is merked o မှ Pe Daniel Scott Elsie C. Green permit. Page 1 and 2 should be Department of Health end Men importent: if Item 27 is merke eny injury or other traumetic once. 19a. Informant's Name/Relationship (Type, Print) Cynthia D. Ennis (Sister) Cynthia Innis (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2912 Windsor Ave., Baltimore, MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Arbutus Mem. Park: 09/07/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Sonatur of Funeral Service Licensee එරිප්පුව්රිංජා Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, MD 21217 Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sacry ine. Approximate Interval Between Onset and Death and Death mmediate Cause (Final Physician/ encencia PON disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): After this certificate has been signed by the ettending physician and funeral director, page 2 should be detached for use es the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗆 No gar Green æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other Spec 100 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury To the Hospital or Attendin within 24 hours efter deeth.

To the Funerel Director: Aft completely filled in by the fur deeth. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my cause Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) N Charles St. Baltimore State Registrar

8/30/12

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08/313/2012 Ronald Douglas Hayes 4:19 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Rirth Days Hours Min (Month, Day, Year) Director 212-46-9932 1 X M 2 □ F 12/02/1946 MD 65 Usual Residence of Deced ir then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1019 DeSoto Rd. 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pege 1 end 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) Siding Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Marshner William Charles Hayes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1019 DeSoto Rd., Baltimore, MD 21223 Dianna K. Hayes / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 6 09/04/2012 Glen Burnie, MD Atlantic Crematory injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home 21. Signature of Funeral Service Licensee Daniel Simons 4107 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a construence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir attending physician and for use as the burial-transit or Attending Physicien: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires that the deeth certificete be exe within 24 hours after death.

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 ∐ Yes 2 L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify, Hospital: 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

only one 29b. Signature

31. Date filed (Month, Day, Year)

30. Name and

title of certifie

7

6701

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License numbe

N. Charles

TONSON MM)

				Please	Type or Pri	int in B EM#5pe	Black Ir	ndelib	le Ink	C. Ensu	re All	Copie	s Ar	e Legi	ble.		
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	Medic Examin		4a. Facility Name (if I	not institution, give	. 1		100		, Town, or	Location of I	Death			c. County o	Death	1 . 1	
	Funeral		5. Social Security Nu 21,2-76-2		ey Hous	ge (In yrs. las	st birthday)	If Unde Months		If Under 24	Hrs. 8	. Date of Bi	rth	- //	g. Birthpl Counti	lace (State	or Foreign
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	th the N 3a or 28 t be not		10e. Street and Num		SI	1 d	266	10f. Zi	p Code	1218			10g. C	itizen of W	hat Count	ry?	
	death wi	Funeral	11. Marital Status	, 33rd	12. Was Decedent	Ever in U.S.	13. Y	Vas Dece	dent of Hi	spanic Origin n, Mexican, F	? (Specif	y Yes or No	-	14. Race			
980	s after or ral", or Examin	ed by	1 Never Married 2 Married 1 Yes, ( 3 Widowed 4 Divorced Fear or Year or			<b>(</b> No				Specify:	derto i ilc	an, e.c.,		Specify:	, White, e Blac	ic. LK	
Jan 21215_0036	72 hour in "natu dedical	Completed		15. Decedent's E cify only highest gr	ade completed)		16a. Deced	lent's Usu kind of wo O NQT us	ork done a	ation luring most o	f working		16b.	Kind of Bus	siness/Ind	ustry	
	d within ygiene.	Be Cor	Elementary/Seco		College (1-4 or	5+)	Bu	ldin	19	Bervi				5+, F	ran	cis	
	d be file Aental H Irked of	To B	17. Father's Name (F	irst, Middle, Last)	arl H	taze	l			18. Mother's	s Name (F	irst, Middle C	T	n Surname) 1 <i>e</i> S			
Maryland	2 should the and he stand he s		19a. Informant's Na	me/Relationship (T	1 1 11		19b. Mailir	ng Addres	s (Street a	and Number o	a 1	oute Numb	<u> </u>	4.4.5			10
			20a. Method of Disp		Removal from State	20b. Pla	ace of Dispo metery, cren				Dat			Location - 0			<u> 40                                   </u>
altimore	mit. Pag bartmen sortant: / injury			5 Other (Specia	51)	IDu	laney	Name a	CV Mondares	em. U	18/2	arch	FIH	mium - Eas	-		
ă	permir Depar Impor any in		220 Port 1 Enter th	The F	plications that cause	d the doath	l l	OLE	No		ve.			re, r	10 2	1202	
	Physician/			t failure. List only o inal	ne cause on each lin								rrest,			Approximation Interval Be Onset and	etween
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):														
9	Sit o	Examiner	Sequentially list cor if any, leading to im cause. Enter Under	mediate lying	b. Due to (or as	a conseque	ence of):										
B	executed lan and urial-transit		that initiated events c														
(M)		edica			d												
Am	9 <u>1</u> 1 8	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 n		23c. If yes, outcome	2 🔲 Fetal	death 3			у				23d. Date Mon		ry Day	Year
_ c	that the death c	hysic	1 Yes 2 9 Unknown		4 Pregnant a 9 Unknown			Other (s						141011		Day	Teal
(S)	requires that been signed should be de		Part II. Other signifi	cant conditions o	ontributing to death I	but not resul	Iting in the u	nderlying	cause giv	en in Part I.				use contrib			death?
$\mathcal{O}_{\mathbf{Z}}$	law requ has been ge 2 shou	Completed by										24a. Was	yago	pr	nor to con	sy findings	s available cause of
3	ician: The la certificate ha rector, page		25. Was case referre	d to medical					26. Pla	ace of Death	(Check or	1 ☐ Yes	ormed?		eath?	2 No	-
5	Physician: this certific ral director,	၉	examiner? 1  Yes 2  27. Manner of Death		Hospital: 1  Inpat	tient 2 🗆 E	R/Outpatier		Othe	er: 4 🏻 Nurs	ing Home	5 ☐ Res				Wos	PILE
	ttending death. stor: After y the fune	Certificate:	1 Natural 2 Accident	5 Pending Investigation 6 Could not b	(Month, Da	ay, Year)	injury	м	28c. Injury work 1 🗆	rat ? Yes 2 □ N		d. Describe	how inju	iry occurred	d		
	al or Att s after de l Directe	Certi	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of In	jury - At hom tc. <i>(Specify)</i>		et, factor	y, office		28	f. Location ( City or To			or Rural I	Route Nun	nber,
X	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of	examination a	and/or invest	tigation, in	my opinio	n, death occu	irred at the	e time, date	and place	e, and due	to the caus	se(s) and m	nanner stated,
01	To the within 2 To the comple	Σ	only one) 3 29b. Signature and t		se Practitioner: To th	he best of my		29	c. License	number				ate signed			
1	1/		30. Name and addre	haef 7	completed Jause of C	death (Item 2	23a) (Type, F	rint)	000	2290 len B	>		9	13/13	Z_		<del></del> -
	7		Michin	el G.	HAYES,	MO		292	in	len la	we.	212	201				
	Sta Registra		31. Date filed (Month SEP 0	7 2012	Service 2	rar's Signatu											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER D HYMAN 2012 CARL 6:29 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 212-62-6750 1 X M 2 □ F 57 03/10/1955 Usual Residence of Deceder MD ir than "natural", or itsms 23a or 28a-f show the Medical Examinar must be notified at filed within 72 hours after death with tha Maryland al Hyglana. al Hyglana. d other than "natural", or Itams 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 221 STONY RUN LANE, 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ DIRECTOR INTERNATIONAL TESTING Be parmit. Paga 1 and 2 should ba filed Dapartment of Health and Mantal Hy Importent: If Itsm 27 is marked off sny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HYMAN EVELINE SHANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARITA HYMAN/WIFE STONY RUN LANE, #H1, BALTIMORE, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CEMETERY 09/06/2012 BALTIMORE, MD When I wice Lice 21. Signatur 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) SQUAMOUS cell lung concer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed attanding physician and I for usa as tha buriai-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signad by tha a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Director: After this certificate has been sin by the funeral director, page 2 should 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 💆 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 ☐ Yes 2 No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Pother (Specify) Wash (Le 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No aftar daath Director: Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours aft To the Funsral Di complataly fillad in Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

MANON

31. Date filed (Month, Day, Year)

6701

N. Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANUEL

M)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

ST PW SON MD

Scotember 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06640 2012 28560 State of Maryland / Department of Health and Mental Hygiene Gertie Horton 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Gertie Mae Horton Dav **Medical Examiner** September 2, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2207 East North Avenue Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Age (In yrs. last birthday) **Funeral** 5. Social Security Number 241-56-0398 Months Day Hours Min Country) NC Director 1 M 2 74 F Yrs 88 10/19/1923 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County MD **Baltimore** Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Directo 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 2207 E. North Avenue 21213 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Yes, Give Yea Yes 2 No specify: Specify. 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agricultural 17. Father's Name (First, Middle, Last) Woodfin Harris 18.Mother's Name (First, Middle, Maiden Surname) Minnie Morgan Be 19a. Informant's Name/Relationship (Type, Print ) Roslyn Foster / Granddaughter 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Cremation Ctr Of MD Burial 2 Cremation 3 Removal from State 9/10/2012 5 Other Specify 21. Signature of Funera Service Licensee 0155 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a Smoke Inhalation and Thermal Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit Sal AMENDED UNPENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by þ Completed page 2 should 24a. Was an autopsy certificate has performed' death? ✓ Yes 2 No

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 14 Rosalie Avenue, Parkville, MD 21234 20c. Location - City or Town, State Hanover, MD 22. Name and Address of Facility
Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes 2 No 26.Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred House fire FOUND: 1 Yes 2 ✔ No 1836 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2207 East North Avenue , Baltimore, MD (Specify) Townhouse / Rowhouse Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 3, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 **ORIGINAL** 

1957 hrs

10d. Inside City Limits

1 Yes 2 No

Black

To the Hospital or Attending Physician:

hours after death. Fo the Funeral Director:

within 24

31. Date filed (Month, Day, State Registrar

Carol H. Allan, MD

29b. Signature and title of certifie

25. Was case referred to medical

Pending

Investigation

Could not be

1 Yes

27. Manner of Death

Homicide

1 Natural

2 🗸 Accident

3 Suicide

Assistant Medical Examiner

28a. Date of Injury (Month, Day,Year) FOUND:

Sep 2, 2012

and manner stated

uneral director,

filled in by

After this

Be

Certification

Medical

one)

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			amend i	tem 26 per State of Mary	verb land/	931 9-7-12 epartment of	Tealth and N	/lental Hy	raiene	,15101	
		•	For State Registrar	,		Certificate of			Reg. No.	110	2056
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath 20	16	3. Time of Death
	Physicia Medic		Jeanet	e Hus	He1			Month Angust	Day 29 2	Year 012	6:20 PI
5.3	Examin	er	4a. Facility Name (if not institution, give s Season's Hospice	treet and number)		4b. City, Town,	or Location of Death		4c. County	of Death	
	<u>′                                    </u>			7 4 4	! 4 1 4	Randall		0.0 : (0:	Balti		
	Funeral Director		170 00 0000	M 2 TTF	yrs. last birth	Months Days		8. Date of Bir (Month, De		9. Birthp Count	place (State or Foreig try)
			Usual Residence of Decedent	2 W 2 X-X	91	rs.		Feb. 2	4, 1921	Iowa	
	/land f sho	tor	10a. State 10b. County		c. City, Town					11	0d. Inside City Limit
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show , the Medical Evanties franct to notified at	irec	Maryland Baltimore	10	atonsv				<u> </u>		1 ☐ Yes XXX N
		<b>Funeral Director</b>	10e. Street and Number 11 Carroll Road			10f. Zip Code 21228			10g. Citizen of What Country? United States		
	eath v	Fune	11. Marital Status	12. Was Decedent Ever	in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe	ecify Yes or No-	14. Rac	ce - America	an Indian,
98	fter d	by	1 Never Married 2 Married	Armed Forces?  1 Yes XX No If Yes, Give		1 ☐ Yes 2 🔀 N		Hican, etc.)	2.00.00		
21215-0036	tural	Completed	3 Widowed 4 □ Divorced	Year or Dates.					Specify	: W11	itte
7	72 hc n "na nedio	nple	15. Decedent's Edu (Specify only highest grad	le completed)		Decedent's Usual Occu Give kind of work done ife. DO NOT use retired	during most of work	ing	16b. Kind of B	usiness/Ind	dustry
72	within glene. er tha	ဒီ	Elementary/Secondary (0-12)	College (1-4 or 5+)		retary	-7		Printin	.g	
ba	filed v al Hyg d other vent,		17. Father's Name (First, Middle, Last)		•		18. Mother's Nam			e)	
Maryland	ild be Menti arked atic e	မ	Leopold P. Jauron				Eva Marie	Chico	ine		_
Nar	shou rand		19a. Informant's Name/Relationship (Typ			Mailing Address (Stree				. ,	,
e,	and 2 Health em 2: ther t		Susan B. Fewster/ 1 20a. Method of Disposition			Carroll Rd Disposition (Name of			20c. Location		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examinates.		1 A Surial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery	, crematory or other pla	ace)	Date			
altir	nit. Partme		21. Signature of Fureral Service License		New Ca	thedral Ce	m. Sept. ress of AMBROSI	FINERA	l Baltim ∆I HOME	ore,M	laryland
ñ	an per		Matino	n Co	~	1	hur Spring				
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	cations that caused the	death. Do no						Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition		rotic c	arzoiosa.	sinley D.	Stare	·		Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of	):	<del></del>				
		e.	Sequentially list conditions,	Due to (or as a co	anoguenes ef	۸.				_	_
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	nsequence or	).					
	xecut n and al-tra	Exa	that initiated events resulting in death) Last	Due to (or as a co	nsequence of	):					
0	te be executed nysician and he burial-transit	ical	L.	I							
Box 6876	eath certificate b attending physi d for use as the t	Completed by Physician/Med	IF FEMALE:								
9 X	th cer ftendii or use	jan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐	Fetal death	3 Ectopic pregnar	ncy			te of delive	
	the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	e of death	5 Other (specify)			IVIC	onth	Day Year
P.O.	that the des	틴	Part II. Other significant conditions con	tributing to death but no	ot resulting in	the underlying cause of	given in Part I.	23e. Did t	obacco use cont	ribute to the	e cause of death?
	rires the significant because	8						1 🗆	Yes 2-10	3 🗌 Prob	abiy 4 🗌 Unknow
ord	w require s been si 2 should l	Set						24a. Was		Were autop	sy findings available
<b>3ec</b>	The law cate has page 2	ا ق						auto perfo	ormee!	pnor to con death? 1  Yes :	npletion of cause of
a	ician: T certifica rector, p	Be	25. Was case referred to medical examiner?			26.1	Place of Death (Check		2 🗆 140]	1 103	2010
Ξ	Physic this ce al dire	욘	1 Yes 2 No			patient 3 LI DOA	her: 4  Nursing Ho	me 5 Resi	dence 6 🛣 Oth	er (Specify)	hospice
0	Attending Physician: The law requires that the death certificate be executed as death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yea	ar) 28b. Tir inj	ury wo	ıryat rk? ∐Yes 2 □ No	28d. Describe h	now injury occurr	ed	
siol	or Attend ifter death Director: A in by the	Ĕ	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home, fam	M 1 L		28f. Location (	Street and Number	er or Rural	Route Number
Division of Vital Records,	al or A s after al Direct	ဦ	4 ☐ Homicide determined	building, etc. (Sp				City or Tov			
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	cian: To the best of my leer: On the basis of exami	knowledge, de	eath occurred at the tin	ne, date and place, a	nd due to the ca	ause(s) and mann	ner as state	d.
	To the H within 24 To the F complete		only one) 3 Certifying Nurse	Practitioner: To the bes	st of my knowl	edge, death occurred at	the time, date and pla	ace, and due to	the cause(s) and n	nanner as st	tated.
	<b>ૄ વ</b> હું	- 1	29b. Signature and title of certifier	umo		29c. Licen	se number		29d. Date signed	1 (Month, D	Jay, Year)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N SWYMNLHMD 263 5 SM (M N ) 72 53 31. Date filed (Month, Day, Year) \_

32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011 Please Type or Print in Black Indelible Ink. Ensure All Copies Are 2 egible
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	ertificate of De	ath	Reg. No.	
	Physicia	an/	Decedent's Name (First, Midd William		Handri	Tue	2. Date of D	Death Day	3. Time of Death
- may	Medi Examir		4a. Facility Name (if not institution	Leon	Hardy	Jr.	Month ©8	31 20	012 6:04am
	Lxamii	iei	FRANKLIN SQU		CENTER	4b. City, Town, or Lo		4c. County of	CTIMORE
	Funeral	Г	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8. Date of E	3irth	9. Birthplace (State or Foreign
	Director		217–90–3661 Usual Residence of Decedent	1 <b>∑</b> M 2 □ F	39 Yrs.	World Suye		Day, Year) 29,1973	Maryland
	and show	Ď	10a. State 10b. Count	у	10c. City, Town or L	ocation			10d, Inside City Limits
	ne Maryland or 28a-f show notified at	irect	Md. B	altimore		Parkvi	lle		1 Yes 2X No
	with the 23a cast be	Funeral Director	10e. Street and Number 23 Bayberry	Road		10f. Zip Code	234	10g. Citizen of W	hat Country?
	death items		11. Marital Status	12. Was Decedent E		Was Decedent of Hispa	unic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)		- American Indian,
Maryland 21215-0036	e filed within 72 hours after death ttal Hygiene. st other than "natural", or items event, the Medical Examiner mu	ted by	1 Never Married 2 XMa 3 Widowed 4 Divorce	d If Yes, Give Year or Dates.	No	1 Yes 2 XNo S		1	White, etc. White
15-	72 ho in "na Medic	Completed	(Specify only high	ent's Education nest grade completed)	(Give	edent's Usual Occupation kind of work done duning	n ng most of working	16b. Kind of Bus	siness/Industry
212	filed within 72 al Hygiene. I other than '	Cor	Elementary/Secondary (0-12)	College (1-4 or 5-		ical Proces	s Operator	Can C	ompany
nd	filed al Hy d oth vent	Be c	17. Father's Name (First, Middle,				. Mother's Name (First, Middle		7
yla	should be file and Mental P 7 is marked o raumatic eve	မ	William Leon				Doreen Carol	Marrs	
e, Mar	of Health and Ments of Health and Ments fitem 27 is marked r other traumatic e		19a. Informant's Name/Relation Shirley Hardy	ship (Type, Print) Wife	23 1	Bayberry Ro	Number or Rural Route Numbad, Parkville	per, City or Town, Sta Maryland	ate, Zip Code) d 21234
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other			osition (Name of matory or other place)  Cemetery	September 5, 2012	I	City or Town, State re, Maryland
Bal	permit Depart Impor any in		21. gnature of Funeral Service	Licensee Conn	elly 2	Connelly Fi	fracility uneral Home of rs Point Road	f Dundalk,	, P.A. Md. 21222
			23a. Part 1. Enter the disease, of shock, or heart failure. List	only one cause on each line.	the death. Do not en	ter the mode of dying, su	uch as cardiac or respiratory a	arrest,	Approximate Interval Between
4	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. CARDIA	C ARRES consequence of):	T			Onset and Death
7	Examiner						DICENC		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):	I'L HEAK)	DISEASE		
X	cuted nd transit	kam	Cause (Disease or injury that initiated events	c					
m	e exe cian a ourial-	a E	resulting in death) Last	Due to (or as a	consequence of):				
928	tificate be executed ng physician and as the burial-transit	Medical Examiner		d					
89	certifi inding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy		-	23d Date	of delivery
Box	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at 1 9 Unknown	☐ Fetal death 3 l time of death 5 [	☐ Ectopic pregnancy ☐ Other (specify)		Mont	*
P.O.	that the	by Pi	Part II. Other significant conditi		t not resulting in the	underlying cause given i	n Part I. 23e. Did	tobacco use contrib	oute to the cause of death?
ds,	quires en sig ould b	ted	HYPERTENS!	on			1 🗆	] Yes 2 🔀 No 3	B ☐ Probably 4 ☐ Unknown
000	law re has be e 2 sh	nple					24a. Was	opsy pri	ere autopsy findings available ior to completion of cause of
Re	ו: The ficate אי, pag	S	05 M-				1 X Yes	formed? de	eath? □ Yes 2 🛱 No
/ita	siciar s certif	To Be	25. Was case referred to medical examiner?  1 X Yes 2 □ No	Hospital:		Other	of Death (Check only one)		
of	g Phy er this neral o		27. Manner of Death	28a. Date of injury		f 28c. Injury at	Nursing Home 5 Res	how injury occurred	
ion	eath. or: Aff the fu	fica		gation	Year) injury	work? M 1 ☐ Yes	2 🗆 No	, , ,	
Division of Vital Records,	after d after d Direct	Certificate:	3 Suicide 6 Could 4 Homicide determ		- At home, farm, str (Specify)	eet, factory, office		(Street and Number own, State)	or Rural Route Number,
	lospita t hours uneral ely fille	Medical	29a. Certifier 1 K Certifying (Check 2 Medical	Physician: To the best of m	y knowledge, death	occurred at the time, da	te and place, and due to the o	cause(s) and manner	r as stated.
	thin 24		only one) 3 Certifying 29b. Signature and title of certifie	Nurse Practitioner: 10 the I	pest of my knowledge	, death occurred at the tir	me, date and place, and due to	the cause(s) and mai	
	⊢≯∺೮		) I WO			29c. License nun		29d. Date signed (	Month, Day, Year)
	6	-	30. Name and address of person	who completed cause of dea	ith (Item 23a) (Type. I			1,0	1, WIL
	8		DR DWYER, MIC				DR. BALTIMOR	e mo	21237
	Stat Registra	_	31. Date filed (Month, Day, Year) <b>SEP 0 7 2012</b>	32. Registrar	Signature	,	DR. BALTIMOR		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per INF C935 1/25/2013 IIII amend #5tate of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 Year 2012 Month 08 Physician/ Dorothy Dacy Hearn 5:10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 910 Patton Drive Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) 5. Social 78 uri36 um4234 (Month, Day, Year) 02/03/1923 **Funeral** Country) Months Days Hours 1 □ M 2 □X 89 DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or item. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20901 910 Patton Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. ģ 1 Never Married 2 Married ☐ Yes 2 XNo 1 ☐ Yes 2 ŽNo Specify. Specify. If Yes. Give Completed 3 Widowed 4 Divorced White Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Beulah Smith Alexander Dacy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Kay Haller / Daughter 4820 Davenport St., NW, Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20c. Location - City or Town, State Chesapeake Crematory 9/2/2012 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lice Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician End wavs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the at Id be detached fo ☐ Yes ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Debili 1 Yes 2 No 3 Probably 4 Unknown Completed stive Iteant Failure 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No page 2 s has 1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) Hospital 1 🗌 Yes 2 📜 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Kertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R098788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Way Banken GRUP 11800 Tech 01 e #240 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Vivian Ann Harrell September 12:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery Wilson Health Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗌 M FIorida 1926 227-26-0861 85 Director Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits ?7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10413 Grandin Road 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White Specify. 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed with and Mental Hygies 7 is marked other the Offset Compositor Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Pryor Wilkerson Gladys Amy Hilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:s Department of Health an Important: If item 27 Is any Injury or other trau Judith A. Harrell/daughter/POA 505 67th Ave #8 St. Pete Beach FL 33706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Final Journey Crematory 09/07/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on earn line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emonli /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 No 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Mayor of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 4 hours after death. Funeral Director; After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

31. Date filed (Month, Day

20877

who cpmpleted cause of death (Item 23a) (Type, Print)

olinste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:30 P. M 20ปี2 Catherine May Jones August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel 1048 Dumbarton Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country) Virginia 1 🗌 M 2 🏻 Days 0673071929 83 Director 215 24 8688 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Glen Burnie Maryland Anne Arundel 1 Ves 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 1003 Shoreland Drive items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 0. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 K No Specify. "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 9th Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Percy Jones Bertie Wilder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Jones / Daughter 1048 Dumbarton Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 👿 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 09/06/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 none 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 Yes 2 No 23d Date of delivery ☐ Ectopic pregnancy Month Year 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Wes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy perform 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify, Daughter's 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation after death Director: A 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled i 24 hours a Funeral I Medical

within 24 ho

To the Fune

completed fi

the

State Registrar

29a. Certifier

(Check

only one) 29b. Signature and title

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Elliott Gorbaty 1411 Masion Park Drive Elliott Gorbaty 32. Registrates Signatura

1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Pay, Year)

Glen Burnie, Maryland 21061

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Month 5:10 Ernest H. Septembe Johnson Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Cent. 5. Social Security Humber 15. Sex 17. Age (In vrs. last bir Baltimore N/A **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 219 52 9775 **Director** 1 🛚 M 2 🗆 F 64 04/23/1948 Maryland Usual Residence of Decedent shov 10a. State 10b County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3906 Brooklyn Avenue 21225 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ö þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White "natural", 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked ပ (Unknown) Mary Johnson injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Johnson / wife 3906 Brooklyn Avenue Baltimore, Maryland 21225 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important; If ite any injury or ot 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 09/08/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. maneloe 4001 Ritchie Highway Baltimore, Maryland 21225 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Small basel infarction
Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last blood loss Due to (or as a consequence of) Examin The law requires that the death certificate be executed Ischemic condianyopathy and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Tyes 2 □ No. been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 X Probably 4 ☐ Unknown Hyperlysdenie Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes ျ 1 X Inpatient 2 ER/Outpatient 3 DOA e Hospita. .
In 24 hours after death.
the Funeral Director: After th 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Set trying Prijastatin to the basis of examination and/or investigation, I may opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar

KoKajko, 31. Date filed (Month, Day, Year)

30. Name and address of poson who completed cause of death (Item 23a) (Type, Print)

M.D.

22 South Greene Street Baltimore, MD 2120 32. Registrar's Signature

102528

September

3

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 0 207AM 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** atique Baltimar N/A Gar Birthplace (State or Foreign Country) ocial Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours (Month, Day, Year) 219 40 8143 **Director** 1 □ M 2 🗓 F 69 Maryland 01/18/1943 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1 Yes 2X No Marvland Anne Arundel Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 211 W. 8th Avenue 21225 or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 K Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Gould Electronics Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked or Marie K. Wentker ပ္ Carl C. Kunaniec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Jones / Husband 211 W. 8th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State MD State Veteran Cem. 09/07/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the diseas shock, or heart failure. I Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Xia Medical Due r as a consequence of): Examiner mon Sequentially list conditions rany, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: 2 20 burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical death certificate be P.O. Box 68760 as the t IE FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforn 1 Yes 2 No 1 Yes 2 No After this certificate • Hospital or Attending Physician: '24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0033 Name and address of person who completed cause of death (Item 23a) (Type, Print) South H (2 00 21225 31. Date filed (Month, Day, Year) SEP 0 7 201 32. Registrar's Signature State SEP 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 1aine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore**  
 If Under 1 Year
 If Under 24 Hrs.

 Months
 Days
 Hours
 Min.
 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🎜 F 65 Yrs. 214-46-8101 MD 2-01-1 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ¥Yes 2 ☐ No Director BALTIMORE MD r than "natural", or Items 23a or 28a-f s the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number Avenue-5762 Cedonia USA 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🐪 o Specify: à Specify: BLACK 3™Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) MARYLAND al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) GENERAL HOSPITAL URSING TECH 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be OSEPH WALTER HOLMES BEATRICE STANFORD Is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a\_Informant's Name/Relationship (Type. permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. JONES RD. BALTIMORE, Md, 21244 DAUGHTER KIDGE 2813 DIAMOND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Arbutus Cemetery BALTIMORE, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNCEAR SCUS 21. Signatur of Funeral S rvice Licensee BALT, MORE, MD. 21212 Road. 4905 York 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sep Immediate Cause (Final Physician Sis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5Pication Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of The law requires that the death certificate be executed ig physician and as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) the a 2 NO P.O. 9 Unknown signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 09 2 No 3 Probably 4 Vonknown 1 TYes plnods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an non autopsy performed? certificate has page, 2 No 2 -No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation After Injury or Attending 1- Natural within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year,

51

State Registrar

SEP 0 7 2012

levence

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature.

4940 Eastern Avenue, Baltimore, MD, 21224

5-000

20 Stember

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State of M State Registrar	aryland / D )	epartment of Hea Certificate of Dea	aith and M <i>ath</i>	lentai Hyg ı	Reg. No. 2 (	12 28569
	Physicia		Decedent's Name (First, Middle, Last)     Rae Jones				2. Date of Dea Month Augus	Dav	3. Time of Death 2:00 A M
€.	Medic Examin		4a. Facility Name (if not institution, give street and number) 747 S. Atwood Rd.		4b. City, Town, or Loc Bel Air	cation of Death		4c. Count	y of Death
4	Funeral			e (In yrs. last birtho	day) If Under 1 Year If	Under 24 Hrs.	8. Date of Birti	h	Birthplace (State or Foreign Country)
	Director		140-40-9229 1 ☐ M 2 🕱 F  Usual Residence of Decedent	65 <sub>Y</sub>	rs.		Feb 10,		New Jersey
	ryland -f shov ied at	Director	10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 🌁 No
	the Ma or 28a e notif		MD Harford  10e. Street and Number	Bel.	10f. Zip Code				What Country?
	th with ms 23a must b	Funeral	747 S. Atwood Rd.		21014	. 0	- I	USA	
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent I Armed Forces?  1 ☒ Yes, Give Year or Dates.	1072	13. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🛣 No S	nt of Hispanic Origin? (Specify Yes or N y Cuban, Mexican, Puerto Rican, etc.)    No Specify:		Bla	ce - American Indian, ick, White, etc. White
15-0	72 hou in "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed)	(	Decedent's Usual Occupation Give kind of work done during ife. DO NOT use retired)	n ng most of workin	ng	16b. Kind of E	Business/Industry
212	led within Hygiene. other tha		Elementary/Secondary (0-12) College (1-4 or s		onvenience store				
Maryland 21215-0036	should be filed and Mental H 7 is marked ot raumatic ever	To Be	17. Father's Name (First, Middle, Last) unk		18.	Mother's Name			ne)
, Man	and 2 shoul Health and I tem 27 is ma		19a. Informant's Name/Relationship (Type, Print) Thomas Jones - husband	19b.	Number or Rural 1 Rd; Be	Route Number L Air,	MD ° 21°01	State, Zip Code)	
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state		Disposition (Name of crematory or other place)	C	)ate	20c. Location	- City or Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses, Ronal d Wade, Dir	ector	22. Name and Address of 655 W. Ba				rd , MD 21201
			23a. Part Enter the disease, or complications that caused	the death Do no		uah an anvalias a	r respiratory arm	est,	Approximate
			shock, heart failure. List only one cause on each line	e.			roophatory an		Interval Between
£.	Physician/ Medical		Immediate Cause (Final disease or condition specifies in death)	bleston a consequence of	re multi				Onset and Death
£.		er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a consequence of	ne multi				
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P.O. Box 68760	Medical Examiner  physician and the burial-transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No	a consequence of a consequence of a consequence of of pregnancy 2   Fetal death at time of death	3 Getopic pregnancy 5 Other (specify)	torne		23d. Di M	Onset and Death  20 multi-
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of Vital Records, P.O. Box 68760	The law requires that the death certificate be executed as the bear signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death in the conditions contributing to conditions conditions contributing to conditions contributing to conditions con	a consequence of, a consequenc	26. Place obatient 3 DOA Other:  28c. Injury at work? M 1 Yes n, street, factory, office	in Part I.  of Death (Check  University Horizontal American Section 1)  ate and place, an eleath occurred at ime, date and place.	23e. Did to  1 1 24a. Was a autop perform 1 1 Yes  only one)  me 5 Resid  28f. Location (S City or Tow.)  d due to the cathe time, date arce, and due to the	23d. Da Molar Sylvano	ate of delivery onth Day Year  tribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes No  ner (Specify)  red  per or Rural Route Number,  uner as stated.  us to the cause(s) and manner stated.
of Vital Records, P.O. Box 68760	ng Physician: The law requires that the death certificate be executed XX fler this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	a consequence of, a consequenc	26. Place obatient 3 DOA Other:  28c. Injury at work?  M 1 Yes  n, street, factory, office  29c. License nur	in Part I.  of Death (Check  University Horizontal Part I)  ate and place, an leath occurred at ime, date and place  of P12	23e. Did to  1 \( \text{1} \)  24a. Was a autop  1 \( \text{2} \) Yes  only one)  me 5 \( \text{2} \) Resid  28d. Describe he  28f. Location (S  City or Tow.)  d due to the cathe time, date arce, and due to the	23d. D. M bacco use con fes 2 No no fes 2 No ence 6 Oth ow injury occur treet and Numb n, State) use(s) and man d place, and du the cause(s) and 29d. Date signe	ate of delivery onth Day Year  tribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes No  mer (Specify) red  per or Rural Route Number, use to the cause(s) and manner stated and manner as stated.  set (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryland		rtment of He			giene Reg. No. 20	12	28570
	Physicia	n/	1. Decedent's Name (First, Middle Last)	Tack	4501			2. Date of Dea	ath		3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give stre		7301	4b. City, Town, or L	ocation of Death		4c. County		1 101
	Funeral Director		216-84-9685	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt uly 20			ace (State or Foreign y) unk
	Maryland 8a-f show tified at	l. h	Usual Residence of Decedent  10a. State 10b. County  MD		Town or Localtimo					10	d, Inside City Limits 1 ☑ Yes 2 ☐ No
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 401 E. 25th Stree	t		10f. Zip Code 21218			10g. Citizen of V USA	What Count	ry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status unk  1  Never Married 2  Married 3  Widowed 4  Divorced	If	Vas Decedent of His Yes, specify Cuban  Yes 2 X No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, et Bla	ck	
Baltimore, Maryland 21215-0036	vithin 72 hou jiene. er than "natu the Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12) unk		(Give k	ent's Usual Occupa ind of work done du NOT use retired)	tion <b>unk</b> uring most of work	ing	16b. Kind of B	usiness Indi	ustry unk
land ?	d be filed v Aental Hyg Irked othe Iic event,	To Be	17. Father's Name (First, Middle, Last) un	nk			18. Mother's Nam	ne (First, Middle,	Maiden Surname	) unk	
, Mary	and 2 should Health and N tem 27 is ma ther trauma		19a. Informant's Name/Relationship (Type, Mercy Medical Cen	ter	30	g Address (Street ar L St. Pau	nd Number or Run l Place;	al Route Numbe Baltimo	ore, MD	21202	<b>-</b> 2102
imore	Page 1 arment of He tant: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☒ Other (Specify) 1	moval from State	emetery, cren	sition (Name of natory or other place		Date	20c. Location	,	vn, State
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	Physician/ Medical		23a. Part Enter the disease, or complications shock or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	tions that caused the death ause on each line.  Due to (or as a consequence of the conseq	h'c 1	the mode of dying	, such as cardiac		rest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, b.	Due to or as a consequ	ence of):						
0	be executed sician and burial-transi	dical Examiner	Cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last  Due to (or as a consequence of):								
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s, P.O.	law requires that thas been signed by 2 should be detact	2	Part II. Other significant conditions contr	ibuting to death but not rest	ulting in the u	inderlying cause give	en in Part I.		obacco use cont Yes 2 \( \subseteq \text{No}	_/	e cause of death?
Record	The law requate has beer page 2 shou	Completed						24a. Was auto perfo 1 Yes	psy ormed?	Were autop prior to con death? 1 \(\sum \) Yes	sy findings available npletion of cause of 2  No
on of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director After this certificate completed filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hos  27. Manner of Death  1  Natural 5 Pending 2  Accident Investigation	spital: 1 Inpatient 2   28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	othe  28c. Injury work?	4 ☐ Nursing H at	lome 5 Resi	dence 6 Oth		
Division	al or Atter s after dea I Director id in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (3 City or Tov	Street and Numb vn, State)	er or Rural	Route Number,
_	he Hospital or iin 24 hours afte he Funeral Dir pleted filled in	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	an: To the best of my knowl : On the basis of examination Practioner: To the best of my	and/or inves	tigation, in my opinio	n, death occurred	at the time, date a	and place, and du	ie to the cau	se(s) and manner stated.
9	To the lawithin 2 within 2 To the lawithin 2 Complete		29b. Signature and title of certifier	esta, A	17	29c, License	1263	:4	AUG	d (Month, E	)ay, Year)
_				STA -	54:	Srint) ST	PAUL	B	2 177NV	76, 1	21215 OL
	Sta Registi		31. Date filed (Month, Day, Year) <b>SEP 0 7 2012</b>	32, Registrar's Signat	Lare	مدا					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28571 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 5. 2012 ROSE KORZENIOWSKI 0630 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In yrs. last birthday) Days Min 217-26-9180 Director 1 🗆 M 2X 🗆 F 85 12/12/1926 WEST VIRGINIA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD PARKVILLE 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8811 RICHMOND AVENUE 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE RETAIL SALES PERSON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ٥ should be SALVADOR LAMANTIA CONCHETTA TERESA FERRA permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH N. KORZENIOWSKI/HUSBAND 8811 RICHMOND AVENUE, PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Donation 5 Cremation 3 Removal from State GARDENS OF FAITH CEM. 9/8/2012 PARKVILLE, MD 21. Signature of Funeral Service Ucensee NO 1739 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My mohocy tic levkemin Physician/ monic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.0. been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed?
☐ Yes 2 2 No. certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nos piu 1 Yes 2 **N**O ൧ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier rancin

Registrar
DHMH 17 Rev 06-2011

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Registrar's Sigi

6701 N. Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 28572 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death alvert mans OWONS Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 95 Days Hours Washington, DC Director 3011 Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😓 No MD Solomons Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20688 11750 Asbury Cir. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White er than "natural", the Medical Exar 1 ☐ Yes 2 🔀 No Specify 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) interior designer interior design other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of 2 Thomas Watson Dixon Frances Ruth Fenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2029\ Rosewood\ Dr;\ Waldorf,\ MD\ 20601$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kathleen M. Kirby daighter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board de 655 W. Baltimore St; Baltimore, MD 21201 23a. Pay 1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) es IN UTE Medical Examiner CARDIOVASCULAR ATTEROSCIFRUTIC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No 9 Unknown signed by the a Id be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed' 2 🗌 No 1 Yes Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 1 NO မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Destrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEIGER FREN ENICK JOITA PRINCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 28573

Certificate of Death

1. Date of Death

2. Date of Death
3. Time of Death

		•	State Registrar		Death		Reg. No	).					
П	Physicia	n/	1. Decedent's Name (First, Middle, La	•	** 1 111				2. Date of De Month	ath Da	y, Year	3. Time o	
	Medic	al	4. 5. 99. 10. 97. 10. 19. 19. 19. 19.	Francis J.	Koolwijk	T (1 0)				-	1 201		45 PM
	Examin	er	4a. Facility Name (if not institution, given Manor Care Wheato			4b. Cit	y, Town, or	Location of Death Wheaton		40	. County of Dea Mor	ntgomery	
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthda	y) If Und	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Bir	thplace (State	or Foreign
-	Director		378-40-0730	1 🖾 M 2 🗆 F	97 Yrs	i. Worth	Days	1 louis   Will.	(Month D	27/191	14 T	he Nether	lands
	nd <b>how</b> at	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside 0	City Limits
	1aryla 3a-f s tified	ecto	MD Mor	ntgomery				Silver Sprin	ng			1 🔀 Ye	s 2 🗆 No
	the N	Ö	10e. Street and Number			10f. Z	ip Code			10g. Ci	tizen of What Co	untry?	
	h with rs 23g nust J	Funeral Director	1121 University Blvd.					20902				SA	
	r deat or iten iiner r		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐XN	er in U.S.	3. Was Dec	edent of Hi ecify Cuba	ispanic Origin? (Sp n, Mexican, Puert	oecify Yes or No- o Rican, etc.)		<ol> <li>Race - Ame Black, Whit</li> </ol>		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland to 7 Health and Mental Hyglene. if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 🗌 Yes	2 XNo	Specify:			Specify:	White	
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lary	d 2 should be file alth and Mental I of is marked o or traumatic eve		19a. Informant's Name/Relationship	Type, Print)	I			and Number or Ru					
S,	and 2 Health		Rita Koolwijk / Wife  20a. Method of Disposition		20b. Place of Di			slvd W., #81					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce.		1 🗆 Burial 2 🖎 Cremation 3		cemetery,	crematory or	other plac		Date /7/2012	200. L	ocation - City or		
altin	nit. Partme vartme vortan injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		, Cliesa	peake C 22. Name a		ss of Facility	7772012	!	Densy	ille, MD	
ä	permit Depar Impor any in once.		Dorota Marshall	usla W. lia	ishell	Maryl	and Cr	emation Ser	vices, PO I	3ox_14	113Baltimo	re, MD 2	1203
			23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	one cause on each line								Approxima Interval Be	etween
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	Medical Examiner		resulting in death)	a. Carob.  Due to (or as a b. Atheroco	consequence of):	ann	1 min	verila	- Asso	2800.			
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):								
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	tificate be executed ng physician and as the burial-transit	al E	resulting in death) Last	Due to (or as a	nsequence of):								
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89	certific nding use as	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy						23d. Date of de	livery	
Вох	death e atte	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at 9 Unknown		3 L Ectopie 5 D Other (		;y			Month	Day	Year
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Division of Vital Records,	al or safter safter al Director		4   Normicide determine	building, etc.	(Specify)				Gity or To	wn, State	:)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exa	nysician: To the best of r	amination and/or in	vestigation, i	n my opinio	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and m	anner stated.
	the lithin 2 the long	Me	only one) 3 Certifying No. 29b. Signature of title of certifier	urse Practioner: To the b	est of my knowled		ourred at the		ace, and due to the		s) and manner as ate signed (Mont		
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	0 1		30. Name and address opperson who now Luni's 20	completed cause of de	ath (Item 23a) (Typ	e, Print)	4711	Par		MI	Zng	12.	
	31		Unoy Lunigo	- 4701 Ka	ndolph	Kd 1	- 616	, KUCK	MIX.	TEL	3 000-	- ·	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Degistral	's Signature	back	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28574 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death raust 201<sup>Year</sup> Physician/ Month ances 31 August 8:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab & Nursing Montgomery Sandy Spring 5. Social Security Number If Under 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, an 13, 1 🗆 M 2 💢 F Country)
Pennsylvania Min Months Days Hours 1917 **Director** 095-03-2462 Tan Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Silver Spring 1 🗌 Yes 2 🔀 No Montgomery 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a 15100 Interlachen Drive #710 20906 USA items ! within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vernon Harrison Kathryn Alvis Richardson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Krause Towers/daughter 237 Amelia Drive McCormick, SC 29835 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematdry 09/04/12 Woodbine, MD Signature of Funeral Service Licen: Going Home CRemation Service P.O. Box 784 MO1251 Heckrotte, P.A. Clarksville, MD 21029 Beverly L. 23a. Part 1. Enter the asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner unonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an or Attending Physician: The law autopsy **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 20860 30. Name and address of pe pleted cause of death (Item 23a) (Type, Print) 8100 SlAdE School Ro 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

SEP 0 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Physician/ September 5,2012 Edward Lawlor . 7:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A St. Joseph Manor- 911 W. Lake Ave 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, 1 🙀 M 2 🗆 F Days Hours Country) Penn Year) Director 100 191 Aug. 426-78-0620 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MAryland N/A Baltimore City 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 W. LAke Avenue 21210 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Roman Catholic Priest Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Lawlor Bridget Broderick 19a. Informant's Name/Relationship (Type, Print) Priest St, Joseph Society Sacred Heart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert St. Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other New Cathedral 1 X Burial 2 Cremation 3 Removal from State Sept 10,2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Baltimore, Maryland inc. 5305 Harford 21214 Rd. 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performe 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year)

(e V

State

Tru

John T. Evelius,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D00

7600 Osler Drive Suite 308

Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and	Mental Hy	giene	2 28576
			State     Registrar     Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physicia Media		Edna Lingreen	Month August	8 2012	9:05 P M
	Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea	th	4c. County of Dea	
		М	Collington Episcopal Lifecare Community Mitchellville  5. Social Security Number 16. Sex 17. Age (In vrs. last birthday)   If Under 1 Year   If Under 24 Hr.			Georges
	Funeral Director		577-60-0254 1 M 2 TxF 99 Yrs. Months Days Hours Min		y, Year) 1912   I	rthplace (State or Foreign ountry) owa
	land show d at	5	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ith with the Maryla ms 23a or 28a-f s must be notified	Funeral Director	MD Prince Georges Mitchellville			1 Tes 2 No
	ith the 3a or it be n	ralD	10e. Street and Number 10f. Zip Code 20721		10g. Citizen of What C	ountry?
	eath w	nue	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Am	erican Indian
36	within 72 hours after death with the Maryland gjene. ier than "natural", or items 23a or 28a-f shc t, the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	to Rican, etc.)	Black, Whi	
2-00	hours natura dical E	olete	15. Decedent's Education 16a. Decedent's Usual Occupation UNK	atria a	16b. Kind of Business	/Industry unk
© 5/1 × 1 × 1 × Maryland 21215-0036	vithin 72 liene. er than the Me	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12)  unk  (Give kind of work done during most of woll life. DO NOT use retired)  unk	irking		
Spu	e filed vrtal Hyg	To Be		ame (First, Middle,		
2 Sign	ould by the market market imatic		Frederick Theodore Lingreen August  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Re	ta Flotho		n Coda)
ZŽ	nd 2 sh lealth a m 27 is ner trau		Joellen Dudycha 4075 W. 51st St #10	08; Edina	MN 55424	p code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	Date	20c. Location - City of	Town, State
Balti	permit. Departi Importa any inju		21. Signature Lyuneral Service Liver & Director 22. Name and Address of Facility S 655 W. Baltimor			21201
2			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arr	est,	Approximate Interval Between
8	Ph, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Cardwartard  a.			Onset and Death
7	Examiner		Due to (or as a consequence of):			
_	sit d	niner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury  b. Due to (or as a consequence of):			
9	executed an and rial-transi	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):			
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ords	v requir	Completed by	Hypotension	24a. Was a	an 24b. Were au	topsy findings available
Division of Vital Records,	'sician; The law r s certificate has b director, page 2 s		- G	autop perfor 1  Yes	med? death?	completion of cause of
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of	rding Physician; T th. After this certifica funeral director, p		27. Manner of Death 1 Attural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 27 Pending (Month, Day, Year) 28b. Time of injury work?		ence 6 Other (Spec ow injury occurred	irty)
sion	Attendir death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28f Location (S	treet and Number or Ru	ral Route Number
Divi	ital or varial or varial Dire		building, etc. (Specify)	City or Town	n, State)	
	To the Hospital or Attending Physician; The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for	Medical	29a. Certifier (Check (Check only one)  1	at the time, date an	nd place, and due to the	cause(s) and manner stated.
	To t with To t	571	29b. Signature and title of certifier  29c. License number  225-79	2	29d. Date signed (Monte	n, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DON 14. Yablanowia, MD Pilo Good Lud	- Ran.	#300 La	nhem no
	Stat Registra		31. Date filed (Month, Day, Year) . 32. Begistrar's Signature . SEP 0.7 2012	· · · · · · · · · · · · · · · · · · ·		3 (
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c per AN BD G931 9/07/2012 JH. State of Maryland / Department of Health and Mental Hygiene

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1	-	Funeral Director		5. Social Security N		6. Sex		yrs. last birth	day) If Und Months	er 1 Year Days	If Under Hours		B. Date of Bir (Month, Da Feb 16	th ly, Year)	0 / 1		lace (State	
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	Page 1 ar	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 ☐ Burial 2 4 ☑ Donation	☐ Cremation	3 Removal fro			Disposition (Na , crematory or		ce)	Da	te	20c. l	Location -	City or To	wn, State	
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2	To the Hospital or Attenning Physician: The law requires that the death certil	within 24 hours arer death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	Medical			Physician: To the xaminer: On the b												anner stated.
	o the l	vithin 2 To the I	Me	only one) 3 29b. Signature and	X Certifying	Nurse Practition	er: To the be	st of my know	edge, death oc	curred at t	the time, dat	e and place	, and due to t	the caus	e(s) and ma	anner as s	tated.	
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State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 28578 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September **p.**<sup>M</sup> Elizabeth Lee 2:33 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll 1680 Bennett Road Eldersburg Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9-25-1945 Year) 1 □ M 2 🗓 F 212-46-5981 66 Director SC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2🏋 No MD Carroll Eldersburg ò 10e. Street and Number 10g. Citizen of What Country? Funeral 23a1680 Bennett Road 21784 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify African-American 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Damestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Forrest Floyd Lena Mae Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Van Lee Jr./Husband 1680 Bennett Road, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Arbutus Memorial Park 1 X Burial 2 Cremation 3 Removal from State 9-8-12 4 Donation 5 Other (Specify) Arbutus, MD 21. Signatur of Furieral Service Liee 22. Name and Address of Facility Willie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 Bart 1. Enter the disease, or conshock, or heart failure. List only ilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of anding physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Turge Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 0 MD TOVISON ND ZIZOY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Audrey M. Luckart 11:15 AM Medical 9 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2 Allanbrook Court Towson Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 219-05-9008 Director 92 1 □ M 2 🗶 F May 20,1920 Maryland 28a-f shov 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2 Allanbrook Court 21204 U.S.A. "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Giv 3X Widowed 4 □ Divorced Specify:White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker At home 12 0 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental ပ Claude D. DePrine Annie L. Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Williams 2 Allanbrook Court, Towson, MD 21204 / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Important: I any injury o 4 Donation Other (Specify) Loudan Park Cemetery 9/10/2012 Baltimore 21. Signature 22. Name and Address of Facility
Parkview Funeral Home & Cremation Service 7527 Harford Rd, Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, burial-transit Exam and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Year Pregnant at time of death Other (specify) Month Day 1 Yes 2X No 9 Unknown Division of Vital Records, P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural iniury work?
1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

EP 0 7 2012

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day 4, Physician/ 2012 10:20 AM James Lynch, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min 216-12-4798 **Director** 1 🗶 M 2 🗆 F Yrs. 90 August 10, 1922 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items once any injury or other traumatic event. the first section once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6809 Stonewood Terrace 20852 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. Specify: White WWII 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Mary Elizabeth Flaherty James Lynch, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6809 Stonewood Terrace, Rockville, Maryland 20852 Helen O. Lynch / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burlal 2 ី Cremation 3 ☐ Removal from State September Montgomery Crematorium, In¢ Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7, 2012 21. Signature of Fungral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-2805 projele tie Bringent 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗓 No Other: ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2 D0063195 September 4, 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilkes, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

ORIGINAL

32. Registrar's Signatur

S. Jakel

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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State of Maryland / Department of Health and Mental Hygiene  Cortificate of Death  Regular Department of Health and Mental Hygiene  Cortificate of Death  Regular Department of Health and Mental Hygiene  To Declares Note of Section (1982)  In Declares Note of Section (1982)  The Annual Property of Section (1982)  The Annual Prope				Pleas	e Type or F					_		_		
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Description of the control of the			5. Social Security Nu	umber 6.				If Under 1 Ye	ar If Under 24		irth Day, <u>Ye</u> ar)	9. Bi	rthplace (State or For	reign
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Ahrym Balant M.D. D0055157 9 6 2012  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  9 600 North Point Rd Fort Howard MD 21052	ne death certif the attending ched for use a	ysician/N	23b. Was decedent in the past 12 r 1  Yes 2	months?	1 Live Bir 4 Pregna	nt 2 ☐ Fetant nt at time of o	al death 3						*	
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9600 North Point Rd Fort Howard MD 21052	To the Total		29b. Signature and t	title of certifier	land	7, M	٥,	_		7	29d. Da	01.1		
21 Data filed (Month Day Vaar) 20 Dagishayla Cigarahyya	6		^		A .	of death (Item			lar d	MD	210	52		
					Server 32. Reg	istrar's Signa	arke							

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		1- For State Registrar	ato or maryiana / B	Certific	ate of D	eath		, g	eg. No.	•	
Physicia Medical Examir		Darryl	e,Last) Lovelle	ette				2. Date of Dea Month Septembe		ear	3. Time of Death 0405 hrs
		4a. Facility Name (if not institution Johns Hopkins Bayvie				City, Town, o altimore	r Location of De		4c. County		
Funeral Director		5. Social Security Number 212–35–9623	6. Sex 7. Age (In	yrs. last birt		Under 1 Year Months Day			rth (MM/DD/YYY 2, 1987		hplace (State or n untry) <b>Missouri</b>
Maryland 28a-f show any datonce.	jo		ltimore 10c.	. City, Town		Essex	:				10d. Inside City Limits  1 Yes 2 X No
n the Mary 3a or 28a	Director	10e. Street and Number 1814 Beechwoo	d Ave.		10	of, Zip Code 21	221		I 0g. Citizen of W	Vhat Coun USA	itry?
after death with the Maryland al", or items 23a or 28a-f aho ner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Dive	12. Was Decedent Ever Armed Forces? 1 Yes 2 X  If Yes, Give Year or Dates:		If Yes, s		n, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ite, etc. Wh	can Indian, Black,
2 hour	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12 years	College (1-4 or 5+)	ed) 16a. i			ation (Give kind o DO NOT use r DET		16b. Kind of B	atern	
215-0(be filed wintal Hygierrked other	8	17. Father's Name (First, Middle, Darryl Lovelle						me (First, Middle, a Holter		e)	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	۵	19a. Informant's Name/Relations Geraldine Nomm	Grandmother		1814 B	eechwo	od Ave.	ESSEX,	Marylan	d 212	221
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		4 Donation 5 Other Sp	3 Removal from State	cremate	of Disposition ory or other p EW Crea	matory	, Se 7	ptember , 2012		ore,	Maryland
Balt permit. Depart Import injury		21. Signature of vieral Service	28/		F 71	10 SOT	<u>lers Po</u>		, Dunda.	LK, N	1d. 21222
Physician  Medical  Examiner		23a. Parf I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease			t enter the m	ode of dying	, such as cardia	c or respiratory an	est, shock, or he	∍art	Approximate Interval Between Onset and Death
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760, ciate be executed physician and the burial - transit	Medical E	UNPENDED	d AMENDED								
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	4 Pregnant at time	2		eath 3 (Specify)	Ectopic preg	nancy	23d. Date o Month		ay Year
that the de ned by the detached f	by Phy	Part II. Other significant conditi	9 Unknown	not resulting	j in the unde	rlying cause	given in Part I.				he cause of death?
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	E Com	25. Was case referred to medical	UI .			26.Place	e of Death (Chec	1 ✔ Yes		death?	s 2 No
Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient		utpatient 3	<del>_</del>	<u> </u>	sing Home 5		Other:	
ion of tending Pl eath. tor: After the funera		27. Manner of Death  1 Natural 5 Pend 2 Accident Inves	28a. Date of Injury (Month, Pay Year) ing tigation	28b. 1 0252	Time of Injury ! hrs		ury at Work? Yes 2 ✓ No	28d. Describe Subject was	how injury occur s stabbed	тed	
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Division of Yo the Hospital or Attending Physical or Attending Physical Drector: After the Completely filled in by the funeral	Medical (	(0.10011 0.11)	nysiclan: To the best of my kno niner: On the basis of examinat and manner stated								
F s F S	ž	29b. Signature and title of certifier				29c. Licens	se number M.E.		29d. Date sign		
Ø	-	30. Name and address of person Pamela E. Southall, M		_	900 \	<u> </u>		Itimore, MD 2	<u></u>		
Sta	77.7	31. Date filed (Month, Day, Year)	D Assistant Medical  32. Registrar's Si	onature	-	. Daitimor		aminore, MD 2	1443		
Registr	ar	SEP 0 7 2012	Centra B.	park							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 1 Month 128 PM Kelly McBride Lange uaust Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Hours Director 216-82-8676 1 🗆 M 2 🔀 F Oct. 1,1961 Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 17551B York Road 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗙 No If Yes, specify Cuban, Mexican, Puerto Rican, Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 XDivorced Specify Caucasian Year or Dates Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Darl Read McBride Emma Jane Fielding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Lynn Wells/daughter 17551B York Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/6/12 Woodbine, MD 21. Signature of Juneral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. CLarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line rval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consec **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Physician/Medical IF FEMALE es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 2 No 3 Probably 4 Unknown Completed Be မ Certificate:

Box 68760 Division of Vital Records, P.O.

requires that the death certificate be

the Hospital or Attending Physician; The law

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thin 24 hours after deat the Funeral Director: filled in by

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Medical

29b. Signature and title of certifier

30. Name and address of person who co

attending physician

death

Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

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				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of Death (Ch	eck only one)	
1 Yes 2 No	Hospital: Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence 6	Other (Specify)
27. Manner of Death  1. Natural 5 Pending 2 Accident Investigatio		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 Suicide 6 Could not be determined			ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinatio	/ledge, death occurred on and/or investigation, i	at the time, date and place n my opinion, death occurred	e, and due to the cause(s) and at the time, date and place,	d manner as stated.  and due to the cause(s) and manner stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

State Registrar

GAUMS 31. Date filed (Month, Day, Year) 32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04, pay 2012 Physician/ Sept М 0720 Fu-Chi Lung Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Director 579-80-6672 1 XM 2 □ F Aug.13,1927 China 85 or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2X No Prince George's Lanham MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 7317 Green Oak Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 2 1 ☐ Never Married 2 🛭 Married Maryland 21215-0036 Specify: Asian 1 Yes 2 No Specify. Yes, Give Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 lin and Mental Hyglene.
7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Private Practice 5+ Lawyer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygl Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk unk Lung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7317 Green Oak Terrace Lanham, MD 20706 Chiung Lung / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 9/8/12 Woodbine, MD 4 Donation 5 Other (Specify) <sup>22</sup> Name and Address of Eacility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD . Signature of Fuseral Service Licensee M01651 MD21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Cholecystitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Failure to Thrive Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No cate has been signed by the apage 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cerebral aneurysm autopsy performed? r this certificate hara 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မြ hin 24 hours after death.

the Funeral Director: After this

mpletely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I complex only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sept. 4, 2012 D0061887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Radin 1500 Forest Glen Rd. Silver Spring, MD 20910

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 9 04 2012 2:30 Mossman рм Norman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Catonsville Manor Care Woodbridge Valley If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 11/05/1930 Director 367-24-8443 81 Kansas Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Catonsville Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with U.S.A. 21228 303 North Rolling Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 2 □ No 1950-Page 1 and 2 should be filed within 72 hours after d nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 Married Yes Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify. 1954 White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Butler Mossman Lyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 North Rolling Road Catonsville, MD 21228 Marilyn Rose Mossman, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State |Floral Lawn Mem. Gdns: 09/10/2012| Battle Creek, MI 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician, METASTATIC NONSMALL CELL LUNG CARCINOM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, Isacing to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: that the death certificate be executed and-tran that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires cate has been sig page 2 should b Tu URINARY TRACT INFECTION 1 🗌 Yes 2 ☐ No 3 ★Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy perform certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural 1 Yes Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUSINESS

CENTER DRIVE

Certifying Nurse Practioner To the best of my knowledge, death occurred at the time date and place and due to the

29c. License number

REISTERSTOWN,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11:54 PM Physician/ Josephine Anne McBride Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie 120 Warwickshire Lane Apt. If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 212 78 6532 **Director** 1 - M 2 X F 55 Maryland 06/30/1957 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at any injury or other traumatic</u>. 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2X No Glen Burnie Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral U.S.A. 21061 120 Warwickshire Lane Apt. F 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mack Trucks Clerical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine McGinley Hugh McBride 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 120 Warwickshire Lane Apt. F Glen Burnie, MD 21061 Kathy Dorsey / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 09/10/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Por 1. Enter the disease lock, or heart failure. List only one cause on each line 106 LASTOMA MUTIFORME Immediate Cause (Final Plusician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner Que to lor es e conscigionde off if any, leading to immedicause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 5 Other (specify) a  $\square$  Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate 2 26. Place of Death (Check only one) To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be examiner? Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 27. Manner of Dath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of co 30 Name and addres

State Registrar 31. Date filed (Mo

Registrar's Signature

State

Registrar

OCME

Laron Locke MD.

31. Date filed (Month, Day, Year)

Meet and address of person who completed cause of death (Item 23a)

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E

September 4, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Cameron McLean Month James Physician/ 8/301/12 11:14p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Futrure Care Sandtown Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 62 Days Hours Min. (Month, Day, Year) 12/12/49 220-54-1344 1XX 2 🗆 F Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director must be notified MD N/A Brooklyn Park 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21225 Funeral 216 Freeman Street USA 23a death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Deceud... Armed Forces? ¬ ☐ Yes 2 🔀 No Examiner Black, White, etc. ö 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir ury or other traumatic event, the Medical Examir Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 XDivorced Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Salesman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John McLean Valene I. Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 Jonnie-Kay McLean/Sister 1294 Harbor Island Walk, Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 9/1/12 Cremation Center of MD Hanover Maryland 4 Donation 5 Other (Specify) harles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD Signature of Funeral Service Licensee Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ma Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a co **Examiner** Sequentially list conditions, cause. Enter Underlying burial-transit Exam Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequ physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Hospital မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury 28d. Describe how injury occurred iniury Natura 5 Pending s after death. 1 Yes 2 No M Accident Investigation the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours at

To the Funeral D

completed filled is Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one

State

Registrar DHMH 17 Rev 7/2009 29b. Signature a

Date filed (Month, Day,

itle of c

(Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06357 State of Maryland / Department of Health and Mental Hygiene Charles Christopher Mackey 2012 28589 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day August 23, 2012 1114 hrs Charles Christopher Mackey Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 3706 W. Bay Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 241–29–1746 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 3/18/70 Director 42 Country) 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10a. State 10b. County 1 X Yes 2 No MD Baltimore Baltimore 28a-f show notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 3706 West Bay Avenue 10f. Zip Code 10g. Citizen of What Country? 21225 USA Funeral 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Black Yes 1 Yes 2 No specify: Specify 3 Widowed 4 Divorced If Yes, Give Year <u></u> 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse St. Agnes Hospital Baltimore, MD 21215-0036 5+ Compl 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wendell Mackey Joyce Irving Jones Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 319 Bristol Rd Wilmington NC Joyce Jones /Mother 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 9/1/12 Greenlawn Memorial Park Wilmington, NC 4 Donation 5 Other Specify. 24 Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility
Charles L. Stevens Funeral Home,
1501 E. Fort Ave, Baltimore MD Inc. 28401 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Madical Death aAtherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Causa (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and . Physician/Medical AMENDED  $\overline{23a}$ , pt. II, 27, per me, g933 11-5-12 sm X UNPENDED attending physician or use as the burial -The law requires that the death certificate be P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE: 23b. Was decedent oregnant in the 3 Ectopic pregnancy Month Dav Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 ✓ No 3 Probably 4 Unknown History of Pneumonia Completed Division of Vital Records, certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? page 2: performed' ✓ Yes 2 No 1 🗸 Yes 2 No he Hospital or Attending Physician: Thin 24 hours after death.
he Funeral Director: After this certifica pletely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 [ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 24, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Philip Gwynne N	ilip Gwynne McCoy State of Maryland / Department of Health and Mental Hygiene  1- For State Certificate of Death											2859
Physici		Registrar  1. Decedent's Name (First, Middle	e,Last)			Boain		2. Da	Re ate of Deat	eg. No. 20		3. Time of Death
Medical Exami		Philip	Gwynne		Соу			Αι	onth Igust 26			1200 hrs
		4a. Facility Name (if not institutio 4212 Franklin Street	n, give street and nu	mber)		4b. City, Town, or Kensington	Location of E	Death		4c. County of Montgom		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea			Date of Birt	th (MM/DD/YYYY)		
Director		578-48-7451	1 M 2 F	<b>7</b> 6	Yrs	Months Days	s Hours	Min. A	ug. 1	1, 1936	Cour	Washington D.C.
any		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits
<b>≱</b>	_	MD Mont	gomery			ensingto	n					1 Yes 2 No
Maryland 28a-f sho d at once	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen of Wha	it Count	ry?
ith the 23a or		4212 Franklin  11 Marital Status			10 140 140		895	0 ( 0	VN-	United		
eath w	Funeral	1 Never Married 2 Ma		edent Ever in U prces? 2 No		is Decedent of His es, specify Cuban				White,		an Indian, Black,
after d	by Fi		orced If Yes, Give Year or Dates:	(Ukn)	1	Yes 2K No				Specify:		ite
2 hours		<ol> <li>Decedent's Education (Specific Elementary/Secondary (0-12)</li> </ol>	cify only highest grad			it's Usual Occupat ost of working life.			lone	16b. Kind of Busi	ness/Ind	dustry
036 (thin 72 ne.	Completed		4	,	(Ukn)					Govern	ment	t Services
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygene. tem 27 is marked other than "natural", or items 23s or 28s-f she traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle,	•					•		laiden Surname)		
2121 uld be fi Mental I marked	To Be	Horace  19a. Informant's Name/Relationsl	B.	M	IcCoy  19b. Mailing	Address (Stree		samine er or Rural l		$^{ m T}$ nber, City or Town,	horr State, 2	
MD d 2 should the and		Francis E. Fe	nwick / E		4910	Massachu	setts	Ave.1	W #2	15, Wash	ingt	on D.C.
E 2 2 2 2		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal fro	m State	crematory or oth	ition (Name of cer ner place)		Date	-	20c. Location - 0	,	,
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:	Ch		e Cremat		09/05				e, MD
Baf permi Depar Impo injur		Hille Loh	Licensee	M0038		pp Funer 3 Gist A	al and ve., S	l Crem Silve	nation Spi	n Servic rng, MD	es 2(	910
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		used the death	n. Do not enter ti	ne mode of dying,	such as card	diac or resp	iratory arre	est, shock, or hear	t	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Gu  Due to (or as a								$\dashv$	Death
		Sequentially list conditions,	b. Due to (or as a									
	nine.	if any, leading to immediate raise. Finter Underlying Course (Disease or injury that initiated										
ecuted and transit	Examiner	events resulting in death) Last	Due to (or as a d.	consequence o	of):						- 8	
urial urial	dical	UNPENDED	AMENDED									
Box 68760, e death certificate bette attending physical for use as the but	an/Me	IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg irth		tal death 3 [	Ectopic pr	regnancy		23d. Date of d	elivery Da	y Year
OX 6 eath cer attendii	sicia	past 12 months?  1 Yes 2 No 9 Unk		ant at time of de	n oth	ner (Specify)						
that the dened by the	Physici	Part II. Other significant conditi	9 Unkno		resulting in the u	inderlying cause g	iven in Part I	i. [2	23e. Did tol	bacco use contrib	ute to th	e cause of death?
of Vital Records, P.O. og Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detacted.	Completed by							_	1 Yes	2 No 3	Probal	bly 4 Unknown
cords, Faw requires as been sign 2 should be	plete							_ [	24a. Was a autops	sy pri	or to cor	psy findings available mpletion of cause of
tal Recol	mo.							1	yerfori ✓ Yes 2		ath? ✔ Yes	2 No
ital Recional Recion The section of the rector, page	Be	25. Was case referred to medical examiner?	Hospital:	npatient 2	1 50/0-4-4		of Death (Ch			Residence 6	Oth and	
n of Viding Physical L. After this funeral directions	P.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of Ir		y at Work?		Describe h	low injury occurred		scene .
ion (tending eath.	ation	1 Natural 5 Pend 2 Accident Inves	ing FOUND: tigation Aug 26,		FOUND: 1200 hrs	1_ Y	′es 2 ✔ No	Subj	ect shot	self		
Division pital or Attendir ours after death. teral Director: A	Certification	3 Suicide 6 Could	not be 28e. Place	of Injury - At h	ome, farm, stree	et, factory, office b	uilding, etc.		or Town, St	tate)		Route Number, City
DIVIS  **Bospital or A  **Labours after  **Funeral Directed filled in b  **Teneral Directed filled in b  **Teneral Directed filled in b	- 1	29a. Certifier	ysician: To the best	Single Far		red at the time da	te and place			Street, Kensing		
Division of Vital Records, P.O. Box 68760 To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	Concon only	niner:On the basis of and manner st	f examination a	-		-					
F 3 F 3	ž	29b. Signature and title of certifier				29c. License				29d. Date signed		h, Day, Year)
		() (Har lake	W)	o of death the	2201	O.C.N	VI.C.			August 27, 2	012	
13		30: Name and address of person Laron Locke MD. As	who completed caus ssistant Medical			ltimore Street	t, Baltimoi	re, MD 2	1223			
St Regist	ate trar	31. Date filed (Month, Day Year) SEP 0 7 2012	Jeneura 32. Re	gistrar's signate	parkel					·		
			JIVIL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:00 PM 2012 Mildred September 6, Markowski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brightview of Whitemarsh Baltimore Nottingham 5. Social Security Number Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Months Days Mar 19, 90 Hours 216-12-9684 **Director** 1922 1 🗆 M 2 🗙 F Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 1 Yes 2 No Baltimore Nottingham 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8100 Rossville Blvd United States items Was Decedent Ever in U.S. Armed Forces?. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc 1 ☐ Yes 2 No If Yes, Give "natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiers Important: If Item 27 is marked other than any injury or other traumatic event, the Menone. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Telephone Company Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Prochaska Julia Mary Dobry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celine Goins /Daughter 355 Blackburn Pl. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 07 Sep 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 Signature of Funeral Service Lice 22. Name and Address of Facility Cremation and Funeral Alternatives Kebe 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical (ED) MAKKOWSK Vital Records, P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death 9 Unknown detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MENTIA 2 No 3 Probably 4 Unknown 1 Yes page 2 should Were autopsy findings available 24a. Was an prior to completion of cause of death? perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other SSINSTED 4 Nursing Home 5 Residence After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 To the I only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) 2012 12 cause of death (Item 23a) (Type, Print) ONES 32. Registrar's Signature State Registrar

SAMUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8402 2012 08 Gail Louise Mears Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Examiner Salisburg 100m 100 Alle HOSDICE If Under 24 Hrs. 6. Sex If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Oct 18, Oregon 66 **Director** 568-70-7137 1 M 2 XF Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21804 IISA 200 Civic Ave. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+) laborer Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thurmond Oliver Means Myra Louise Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maynard Nostettler - POA 6820 McCabes Corner Rd; Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burlal 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, repear failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph,sii₃n disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Dilly to for each consideration of cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnap 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) Pregnant at time of death signed by the and ld be detached for Yes 2 A No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 Yes Yes 25. Was case referred to predica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completely filled in by the funeral 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A Accident 1 Yes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 60515 cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

TERN SHONE DAI

Physician/

Medical

**Examiner** 

**Funeral** Director

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notified at

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

Certificate: To Be Completed by

Medical

29a. Certifier

only one) 29b. Signature and title of certifier

Kshama Garg, MD, 31. Date filed (Month, Day, Year)

SEP 0 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

with the Maryland

Please	Type or Pri				_	-	e.
For State	State of M	aryland / Dep			Mental Hygi	ene -	
Registrar	-4)	Ce	rtificate of L	Jeatn		g. No. 20	2 28594
Decedent's Name (First, Middle, La	St)				Date of Death     Month	30 2 <sup>Yea</sup>	3. Time of Death 2 06:35 A M
Jane Mitchell					August		
4a. Facility Name (if not institution, give				r Location of Death		4c. County of De	
Holy Cross Hospi  5. Social Security Number 6. S		e (In yrs. last birthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth	Montgome	Birthplace (State or Foreign
261-40-7822	M 2 □ F	84 Yrs.	Months Days	Hours Min.	Nov 24	(ear) 1927 Ne	Country) W Jersey
Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryland Prince	Georges	Beltsvill					1 ☐ Yes 2 🔀 No
10e. Street and Number		-	10f. Zip Code		10	g. Citizen of What	Country?
11208 Montgomery	Road		20705		U	nited Sta	ates
11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,
1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1 ☐ Yes 2 X No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Black, Wh	White
15. Decedent's E (Specify only highest gr	ducation	16a. Dece	edent's Usual Occup	pation	ing 1	6b. Kind of Busines	ss Industry
Elementary/Seconday (0-12)	College (1-4 or 5	ife. L	nemaker nemaker	during most of work	ling	Own Home	e
17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Walter Leroy Gal					cKinley-E		
19a. Informant's Name/Relationship (1)  Perry Mitchell/			ling Address (Street:				Zip Code) Land 20705
20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Condition 5 Other (Special Conditions)	Removal from State	20b. Place of Disp		ce)	Date 2	0c. Location - City	or Town, State
21. Signature of Edneral Service Licen		, 2	22. Name and Addre	ss of Facility <b>Kir</b>	klev-Rud	dick Fune	ral Home
1000	Moisu	4 4	21 Crain	Highway	SE, Glen	Burnie,	Maryland 21061
23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	pplications that caused one cause on each line	d the death. Do not en e.	ter the mode of dyin	ig, such as cardiac (	or respiratory arres	t,	Approximate Interval Between
Immediate Cause (Final disease or condition	UT	I					Onset and Death
resulting in death)	Due to (or as	a consequence of):				•	
Sequentially list conditions,		hydration					
if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequence of): rponatremia	1				
that initiated events resulting in death) Last		a consequence of):		-			
	d. Di	abetes Typ	pe 2		_		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 N No 9 Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death 3	☐ Ectopic pregnand	су		23d. Date of o	delivery Day Year
Part II. Other significant conditions of	contributing to death b	out not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
COPD					1 ☐ Yes	s 2 <b>X</b> No 3□	Probably 4 Unknown
					24a, Was an	24h Wara	autoney findings available
					autopsy perform	ed? death	autopsy findings available o completion of cause of ? //es 2 🏻 No
25. Was case referred to medical examiner?			26. Pl	ace of Death (Chec			
1 ☐ Yes 2 🛣 No	Hospital: 1 🔀 Inpati	ent 2 ER/Outpatie	ent 3 DOA Oth	er: 4  Nursing Ho	ome 5 Residen	ice 6 Other (Sp	ecify)
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Day	ry 28b. Time of injury	work	y at <br Yes 2 \( \) No	28d. Describe how	injury occurred	
3 Suicide 6 Could not t	oe 290 Place of Init	ury - At home, farm, st			28f. Location (Stre		Rural Route Number,

State

completed filled in by the funeral director,

Registrar

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

August 30, 2012

29c. License number

D60826

1500 Forest Glen Rd., Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** McKinney September 6 2012 11:00A M Glen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 14, 1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1- M 2 □ F **Funeral** 236-40-8955 84 West Virginia Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Md. Baltimore Dundalk 1 Yes 2 No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2802 Southbrook Road 21222 LISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - Americen Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ∏ Yes 2 TXNo Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Assembly Line 12 years General Motors .. Pages 1 and 2 should be filed v frnent of Health and Mental Hygie tant: If item 27 is marked other I jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Otto McKinney Bertha Born ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Marsh Daughter 4316 Marigold Lane, Belcamp, Maryland 21017 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 Cremation 3 Removal from State Bel Air, Harford County Bel Air Memorial Gardens 11, 2012 5 Other (Specify) 4 Donation She ature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 21 7110 Sollers Point Road, Dundalk, Md. 21222 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Preum once Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as e consequence of) Leviemio The law requires that the death certificate be executed Lymphocytic nronic burial-trar and Due to (or as a consequence of): Box 68760, iding physician Physician/Medical use as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 - Ectopic pregnancy aften in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) detached f 2 🗌 No 9 Unknown P.O. 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 has 2 XNo Yes 1 Yes certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2√ No **Z**Inpatient 3 🗌 DOA 1 Tyes 2 ER/Outpatient မ he Hospital or Attending Phys in 24 hours after death.
he Funeral Director: After this c pletely filled in by the funeral dir this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital npletely within 2

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Rekner 31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

one)

(check only

30. Name and address

29b. Signature and title of certifier

ef person who completed cause of death (Item 23a) (Type, Print) Rapaka

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

September 6, 2012

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Registrar  1. Decedent's Name	e (First, Middle	, Last)			Cert	ificate	OI L	eaiii	Т	2. Date of De				3. Time o	of Death
ian/ lical	ı					ty Mora	an					Month 09	Da	ay 4	<sup>Year</sup> 2011	2 1:1	5 PM
iner	•	ta. Facility Name (if Riderwoo		, give street and nun	mber)			4b. City, To	own, or	Location of D Silver Sp		!	40		y of Death Prince	George's	S
al	4	5. Social Security No	umber	6. Sex	7. Age (In	yrs. last birth		If Under 1 Months	Year _ Days	If Under 24	<del>-</del>	8. Date of Bir (Month, Da			g. Birth	nplace (State	or Foreian
r		194-24- Usual Residence of		1 □ M 2 □ F		84	Yrs.					12/	F1/192	27	1	ennsylva	inia ——————
toto	5	10a. State	10b. County			c. City, Town	or Loca	ation								10d. Inside C	•
Director	-	MD 10e. Street and Num	L	nce George's				10f. Zip (		Silver Sp	ring	Т	10g C	itizen of	What Cou		s 2 No
Funeral	5	3152 Grac	efield Ro	ad						20904	Į.		, og. o		US	ř	
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DHMH 17 Rev 06-2011

State Registrar Eileen Gemmell, CRNP, 3160 Gracefield Road, Silver Spring MD

31. Date filed (Month, Day, Year)

SEP 0 7 2012 33 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 8:45 Medical Gary Dalton Mathers 09 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Birthplac Country) 8. Date of Birth (Month, Day, Year) 01/15/1943 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Davs Hours Min. Director 1X M 2 □ F 231-56-0152 69 Yrs Page 1 and 2 should be filed within 72 nouse arrows and 2 should be filed within 72 nouse arrows 23a or 28e-f show thant: If item 27 is marked other than "natural", or items 23a or 28e-f show the marked other than "natural", or items 23a or 28e-f show that: If item 27 is marked other than "natural", or items 23a or 28e-f show that: 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director tX☐ Yes 2 ☐ No MD Prince George's Suitland 10f. Zip Code 10g. Citizen of What Country? Funeral 6708 Pine Grove Drive 20746 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 Alfr Force Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Retail injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laurence Mathers Ann Wen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mathers / Wife 6708 Pine Grove Drive, Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of Department of h Important: If ite eny injury or oti 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 9/6/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final YPOGH CEMIA Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed CORONARY ARTERY DISEASE Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 D 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 힏 1 🖺 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0064986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Physician/ Month F. McGill 8:15 James 2012 PMSeptember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Min 084-18-2355 Director 1 X M 2 F 88 Usual Residence of Decedent New York 28a-f show 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD. Baltimore Timonium 1 Yes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2525 Pot Spring Rd. L-318 21093 **USA** . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Hallmark Cards Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James V. McGill Fijux Marjorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shiment of Health a tant; If item 27 is Frances McGill/ Wife Timonium, MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1
Department of Important; If it any injury or o once. cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Dulaney Valley Mem. 9-11-12 4 Donation 5 \$ Other (Santombment Timonium, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Fun al Serve e Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death SEPTEMBER Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has performe death? certificate Yes 2 X No 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 Z No Other 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of MCGILL Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE CRNP 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

HMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		Prince George					Cheverly				P	rince Ge	orge	's	
	=	5. Social Security Numb	<u> </u>		7 Age (In yr	s. last birthday)	If Under 1 Y	ear If Un	der 24Hrs.	8. Date of B	irth(MM/I	DD/YYYYdd	9. Birt	hplace (	State or Foreign
Funeral Director		•			7. Age (III yi		Months D	ays Hou		July			Cou	untry)	
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faryl	Director	10e. Street and Numbe	r				10f. Zip Code	9			10g. Citiz	zen of What	Cour	itry?	
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Division of Vita  To the Hospital or Attending Physicia within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral direct	Medical Certification: To	Car	Investiga Could no determine entifying Physic edical Examine e of certifier	tition fd 28e. Pla 28e. Pla (Specify cian: To the basis and manner	8-13-1 ice of Injury  Multi est of my know s of examinati stated.	At home, farm, stre  -Family  Medge, death occu on and/or investiga	O1 pth Det, factory, office Apt.  urred at the time ation, in my opin 29c. Lice	ce building e, date and nion, death cense numb	place, and occurred at	28f. Location or Town #103 due to the ca	State) 6 Cheve iuse(s) ar te and pla 29d.	erly, I erly, I nd manner a ace, and du Date signe	and MD. as star e to the	led. ne cause	r Rd.
Division of Vita  To the Hospital or Attending Physicia within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral direct	Medical Certification: To	30. Name and address	Investiga Could no determine entifying Physical Examine e of certifier	tition fd 28e. Pla ed (Specify cian: To the basis and manner completed ca	8-13-1 ice of Injury  Multi est of my know s of examinati stated.	At home, farm, stre  -Family  wledge, death occu on and/or investige  (Item 23a)	OI pm  Det, factory, offi  Apt.  urred at the time attion, in my opin  29c. Lic	ce building e, date and nion, death cense numb	place, and occurred at	28f. Location or Town #103 due to the cat the time, da	State) 6 Cheve luse(s) ar te and pla 29d. Aug	erly, I erly, I nd manner a ace, and du Date signe	and MD. as star e to the	led. ne cause	r Rd.
To the Hospi within 24 hou To the Funes Completely fil	Medical Certification: To	30. Name and address Carol H. Allan	Investiga Could no determine entifying Physic edical Examine e of certifier s of person who	tition fd 28e. Pla 28e. Pla (Specif) cian: To the beer: On the basis and manner completed ca	8-13-1 ice of Injury  Multi est of my know s of examinati stated.	At home, farm, stre  -Family  wledge, death occur on and/or investigate  (ttem 23a) iner 900 W.	OI pm  Det, factory, offi  Apt.  urred at the time attion, in my opin  29c. Lic	ce building e, date and nion, death cense numb	place, and occurred at	28f. Location or Town #103 due to the cat the time, da	State) 6 Cheve luse(s) ar te and pla 29d. Aug	erly, I erly, I nd manner a ace, and du Date signe	and MD. as star e to the	led. ne cause	r Rd.

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

For State Registrar

10a. State

MD

Director

Funeral

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Be Completed

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical **Examiner** 

Medical Certification: To Be Completed by Physician/Medical Examiner the burial-tran attending physician cate has been signed by the page 2 should be detached certificate has funeral director this within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

6 ☐ Could not be

3 Suicide 4 Homicide

31. Date filed (Month, Day, Year)

29a. Certifier

To the Hospital or Attending Physician: The law requires that the death cartificate be executed

Division or Vital Records, P.O. Box 68760,

17. Father's Name (First, Midd	dle, Last)			18. Mother's Na	ame (First, Middle,	Maiden Surname)	
HERBERT	MAYFIELD	ELLIS		BEUL	AH	FRAZIER	
19a. Informant's Name/Relati							e, Zip Code 21104
JOHN NUNNAI	LLY/ SON						SVILLE, MD
20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othe	on 3XIRemoval from State or (Specify)	20b. Place of Dispositio cemetery, cremato			Date /8/12	20c. Location - City  LOUISVIL	
21. Signature of Funer 1	ice Licensee	22. Nr L. I 19	LLY & 01 EAS	ŽEILER TERN A	INC. F VENUE, B	UNERAL H	OME 21231
23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a, or complications that caused List only one cause on each lin a. END S Due to (or as a	е.	e mode of dying	1.5	ac or respiratory at	rest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyp.  Due to (or as a gent of the control of the	ertensi nunsiquina uti erticu a consequence of): cul Insu	losis	s ince	)		yrs yrs
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ♣No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ec	topic pregnancy her (specify)			23d. Date of Month	delivery Day Year
	ditions contributing to death but	nt not resulting in the under					e to the cause of death? ] Probably 4 □Unknowr
Immobili Aneroxia	ty Syndra	5ME			24a. Was auto perfo 1 Yes	psy prior ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
25. Was case referred to me examiner?	Hospital:		Otho		eath (Check only o		tssisted IIV
1 ☐ Yes 2 No	1 ∐ Inpatie		3 DOA	4 Nursing	Home 5 ☐ Resi	dence 6 Other (5	Specify)
27. Manner of Death  1 Natural 5 Pe	28a. Date of Injury (Month, Day restigation	y Year) 28b. Time of Injury	28c. Injury Work M 1 □	yat <br Yes 2 ∐ No	28d. Describe	how injury occurred	

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2012

DHMH 17 Rev 1/2001

State Registrar 🛃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Edward 01son 6:00 A M 2012 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthdav **Funeral** (Month, Day, Year) Hours Director 477-20-0279 1**▼** M 2 □ F 85 California March 5, 1927 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits at 10a. State 10b. County Director must be notified 28a-f 1 Yes 2 X No Silver Spring MD Montgomery 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 20910 United States 2303 Coleridge Dr. death \ items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates 1946-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black White, etc. 0 1 Never Married 2 X Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White "natural" Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Defense Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Intelligence Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Heilmann Raymond 01son Flora Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, item 27 10308 Inwood Ave., Silver Spring, MD Quentin Olson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State or 1 Burial 2XXCremation 3 Removal from State Department Important: If any injury or Chesapeake Crematory 09/04/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 21. Sign Jur Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury SEPSIS attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ABDOMINAL INFECTION Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed? death? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ျှ 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director: /
completely filled in by the i 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D67589 SEPTEMBER 1, 2012 ress of person who compl d cause of death (Item 23a) (Type, Print) UX 1500 FOREST GLEN RD., SILVER SPRING, MD 20910 HAROLD LAWSON, M.D., 31. Date filed (Month, Day, Year) State SEP 0 7 2012 Registrar

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PERTNOY SEPTEMBER 2012 ALLAN 5:55 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 K M 2 □ F Days Min Hours 02/11/1937 Director 216-32-5819 MD Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? Funeral 220 RITTERSLEA COURT USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify "natural" Completed 3 Widowed 4 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ the DENTIST DENTISTRY traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ပ JOSEPH PERTNOY LOTTIE BUCKNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 LESLIE BENZION/DAUGHTER 220 RITTERSLEA COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HEBREW FRIENDSHIP CEM 09/06/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS.. Man 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 🗌 Unknown P.O. or Attending Physician: The law requires that the significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 2 No Yes 2 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. Manner of Dealt 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital ledical extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge oth pocurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORE 21215 State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2012 28603 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 11:45 a M ZOIZ JOYCE C. PRICE 09 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE ROSEDALE FRANKLIN SQUARE MEDICAL CENTER Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 💥 F Months Days Hours Min. 73 219-38-8046 MD. Sept.4,1939 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Maryland Baltimore County 1 ☐ Yes XX No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1000 E. Joppa Rd. 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes XX No Specify: White Specify XX Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Super Fresh 8th Grade N/A Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles McLaughlin Georgie Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Keith McLaughlin (Son) 624 N. Curley St. Baltimore, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial 9-8-2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 )than 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): KESPIRATORY Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

**Physician** /Medical Examiner

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page 2 should

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Certification: To

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Hospital or Attending Pl 24 hours after death. Funeral Director: After t

within 24 hours a To the Funeral D

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

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Be Completed

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**Funeral** 

**Director** 

death with the Maryland

21215-0036

Maryland

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PRICE

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Western Exercitive must be neathered ance.

Examiner Physician/Medical IF FEMALE: Completed

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. Date of Injury (Month, Day, Year)

and manner stated.

24a. Was an autopsy performed? res 2 🔼 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1∐Yes 2MiNo 27, Manner of Death 1 Natural 2 Accident

25. Was case referred to medical examiner?

5 Pending investigation 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

28b. Time of Injury

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 5 12

State Registrar

E. Sanchez-900 Franklin Spare Dr. Balks, MD 21237 SEP 0 7 2012 32. Registrar's Si

DHMH 17 Rev 1/2001

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Physi	iciar		1. Decedent's Name (First, Middle,	ast) Dh. 11					2. Date of De	Da	y Year	3. Time o	
Ме	dica	al .	Dennis  4a. Facility Name (if not institution, g	vive street and number)	PS		Ab. Cib. Tours	or Location of De	Hugus	st 2	2012 County of Death		ØFM
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Funer Direct					e (In yrs. la	ast birthday)	If Under 1 Yea Months Days				9. Birth Cou	nplace (State ontry)	or Foreign
			579-68-9702 Usual Residence of Decedent	1 🕅 M 2 □ F		Yrs.			July 4,	195		ington	
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h with na 23a		Funeral	709 65th Ave.				2074				JSA 		
and 21215-0036  be filed within 72 hours after death with the Maryland antel lygiene. ked other than "natural", or Itema 23a or 28a-f show covent, the Medical Examiner must be notified at		침	11. Marital Status 1 ☐ Never Married 2 🛣 Marrie	12. Was Decedent I Armed Forces? d 1 ☑ Yes 2 ☐ If Yes, Give			Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N	ban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race - Amer Black, White Specify: Bla	, etc.	
ours a stural'		ge	3 Widowed 4 Diversed  15. Decedent	Year or Dates.			dent's Usual Occi			16h V	(ind of Business/I		
215 n 72 h s. man "na		Completed	(Specify only highest Elementary/Secondary (0-12)		5+)	(Give life. D	kind of work done O NOT use retire	e during most of w d)	-	1	heating	&	
d withi	1	oo l	12	0		mec	hanical	engineer			air cond	itioni	ng
Viand d be filed Mentel H arked ot		<u> </u>	17. Father's Name (First, Middle, La Alexander Barr	•					lame (First, Middle, Lee Phil		Surname)		
ore, Maryland and 2 should be file of Health and Mentel I litem 27 is marked o			19a. Informant's Name/Relationship Dennis Phillip		ı	19b. Maili 78	ng Address (Stree 01 Mando	et and Number or i on Rd; Gr	Rural Route Number eenbelt,	er, City or MD	r Town, State, Zip 20770	Code)	
Baltimore, Maryland 21215-0036  semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: If lean 27 is marked other than "natural", o any lollury or other traumatic event, the Medical Exam.			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Sp		,   -	cemetery, crei	osition (Name of matory or other p		Date		ocation - City or	Town, State	
Baltimo permit. Page Department or Important: If any Injury or	once.		21. Synature of Funeral Service U.	ensole, Die	ecto	r 2	2. Name and Add	ress of Facility S Baltimor	tate Ana e St; Ba	tomy 1tim	Board ore, MD	21201	
			23a. Part 1. Enter the disease, or or shock, scheart failure. List on Immediate Cause (Final	omplications that caused by one cause on each lin	e.							Approxima Interval Be Onset and	tween
Pnysicia Medic Examin	cal		disease or condition resulting in death)	a. The ut  Due to (or as	a consequ	uence of):	erebic	w nen	without				
si d	١	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):		_	1/1	L		·	
e executed slan end urlal-transit	- 1	- I	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):		T M	PROVED BY MEDICAL	EXAMIN	50		
68760 ertificete be ding physic				d				CERTIFICATION					
Box death o he etten ed for u		Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	☐ Ectopic pregna☐ Other (specify)	incy		8	23d. Date of deli Month	v <b>ery</b> Day	Year
COTCS, P.O. law requires that the las been signed by ti e 2 should be detach		by P	Part II. Other significant condition	s contributing to death to	but not res	sulting in the I	underlying cause	given in Part I.	- 1		use contribute to		
Records, The law requires ate has been sig		Sete	Sepsis						24a. Was	an	24b. Were aut	opsy findings	available
Hec The lav		ë 8							— auto perf 1 ☐ Yes	ormed? 2 🛂 N	/ death?	ompletion of	cause or
Vital ysiclan: is certific director,		8	25. Was case referred to medical examiner?	Hospital:			T <sub>0</sub>	Place of Death (C					
ISION Of VITAI Attending Physician: or death. ector: After this certific by the funeral director,		ate: 10	1 🖾 Yes 2 🗔 No.  27. Manner of Death 1 🗇 Natural 5 🗇 Pending	1 ☐ Inpat	ury	ER/Outpatie 28b. Time o injury	f 28c. Inj	4 Mursing	Home 5 Res			fy)	
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2		Certificate:	2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	ot be			M 1 reet, factory, offic	Yes 2 No	28f. Location (		nd Number or Rur	al Route Num	ber,
Divalor pital or pital or after after piral Direction filled in	١		20.0.17.4.10.17.1			117.67						4.4	
the Hosi thin 24 ho the Fune		Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practitioner: To the	examinatio	n and/or inves	stigation, in my opi	nion, death occurr	ed at the time, date	and place	e, and due to the o	ause(s) and m	anner stated.
To the			29b. Signature and title of certifier	2				nse number		29d. Da	ate signed (Month		
			30. Name and address of person w	no completed cause of	leath liter	n 23a) (Time		05333	7	14	ugus!	3 20	
			Donty Sea	ma 9	106		فأرهم	læne	Clinto	m, 1	Md		
Regi	Stat istra		31. Date filed (Month, Ďay, Year)  SFP 0 7 2	37 Registr	rar's Signa	ture de	Mal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mai	ylanc		tificate of l			Reg. No. 2	112	2860
	Physicia Medic Examin		1. Decedent's Name (First, Middle, Las			2. Date of De Month Septem	ottember 3, 2012 5:30 A					
			4a. Facility Name (if not institution, give street and number)  1605 Angleside Road				4b. City, Town, o	ton		4c. County Harf		
17			5. Social Security Number  230-05-1135  Usual Residence of Decedent	ex 7. Age (I	in yrs. las 94	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	in. (Month, Da	th ay, Year) 24, 1917	9. Birthpla Country Virg	
Cochac		Director	10a. State 10b. County  Maryland Harford	1		Town or Lo					100	d. Inside City Limits
4		Funeral Di	10e. Street and Number 1605 Angleside	Road			10f. Zip Code 21047			10g. Citizen of What Country? USA		y? <u>×</u>
036			11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.	-No		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ★No S <i>pecify:</i>			14. Race - American Indian, Black, White, etc.  Specify:  White		
21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)			(Give	ent's Usual Occupation ind of work done during most of working INOT use retired)		16b. Kind of Business/Industry  Own Home			
Maryland 2		an l	17. Father's Name (First, Middle, Last)  John Walter Basham				18. Mother's Name (First, Middle Ollie M. Crow					
, Mary			19a. Informant's Name/Relationship (7) Dianne C. Snyde		_	1605	Anglesi		Rural Route Number , Fallsto	on, Maryl	and 2	1047
Baltimore,			20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Sherwood Memorial Park 9-7-2012  21. Signature of Funeral Service Licensee  22. Name and Address of Facility McComas Funeral H							Virgi	nia	
Bal			21. Signature of Funeral Service Licens  23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	1 Hury	ly	1	317 Coke	sbury_R	oad, Abir	ngdon, Ma		
	h sician/ Medical Examiner s the privile-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	conseque	ence of):	ncols m					nterval Between Onset and Death
Box 68760	I or Attending Physician: The law requires that the death certifin after death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Completed by Physician/Medical Examiner	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth   2   Fetal death   3   4   Pregnant at time of death   5   9   Unknown				Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year	
s, P.O.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									
Records,			autopsy performed? dd								by findings available pletion of cause of	
of Vital			25. Was case referred to medical examiner? 1								r (Spaciful)	
ion of \		Medical Certificate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	28c. Injui wor M 1	ry at		how injury occurre					
			4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num. City or Town, State)						wn, State)			
To the Hos	within 24 hours To the Funeral completely filled		(Check 2 Medical Examiner: On the basis of examination and/or investigation, i only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death or					rurred at the time, date and place, and due to the cause(s) and manner as stated.  ition, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)				e(s) and manner stated ated.
			Wends The mo  30. Name and address of person who completed cause of death (Item 23a) (Type,				D3/295 9/3/12					
Ψ	Stat	0	Wendy Kloesz 31. Date filed (Modth, Day, Year)	32. Registrar's	e j	Ken wa	ed Aug	, 6501	house i	11 50 cm	مرسع	
	Registra		SEP 0 7 20	12 Come	1	1. 1	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28606 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012  $A^{\;\mathsf{M}}$ 4:24 Georgia Elizabeth Whalen Pratt September\_ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year) 545-12-5941 **Director** 1 □ M 2 🗓 F Yrs California 96 April 3, 1916 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County death with the Maryland Medical Examiner must be notified at 10a. State Director 1 Tes 2 X No Bethesda Maryland Montgomery 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 20814 5419 Edgemoor Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any fining or other traumatic event, the Medical Examin once. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) IBMAccount Executive 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Whalen Lillian Huk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Pratt Porter/Daughter 22 Hickory Avenue, Takoma Park, Maryland 20912 20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State September 5 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 5 Phr 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) bowel perturation Medical Due to (or as a con quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performe death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No M 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar Churche COS

Christine Castro,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.

32. Registrate Signature

67490

8600 Old Georgetown Road, Bethesda, Maryland 20814

09/01

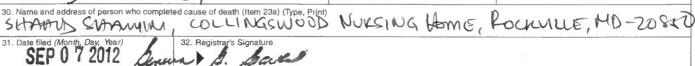
2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 2, 2012 **Physician** Pinnis 5:20 A M Julius G. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Hours 1 X M 2 □ F 215-32-0501 Director 79 April 12, 1933 Latvia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Locetion 10d. Inside City Limits event, the Medical Examinar must be notified at 1XYes 2 No Director Maryland Rockville Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 317 Howard Avenue 20850 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 \( \text{XYes} \) 2 \( \text{No} \) No If \( \text{Yes}, \) Give Year or Dates: \( -1962 \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours efter 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Archdiocese of Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) Washington 9 Stationary Engineer and Mental Hygie Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill Health and Mental H Be Julius V. Pinnis ပ Ana Kurzemnieks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Ina Pinnis / Wife 317 Howard Avenue, Rockville, Maryland 20850 September 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages 1 Department of It important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 7, 2012 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 ROBERT A. FUIDILLEY FULLER TABLE, 1300 West Montgomery Avenue, Rockvil 23a. Parti. Erder the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). HEART FAILURES ONGESTIVE Examiner Georgia tally liet conduct, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-tran Due to (or as a consequence of): attending physician for use as the burla Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No P.0. the 9 Unknown þ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 14No 2 1100 Division of Vital 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Yo ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day, Year) re Hospitel or Attending Pl n 24 hours after death, re Funerel Director: After the bletely filled in by the funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number D - 59284 29d. Date signed (Month, Day, Year) 9/5/12 29b. Signature and title of certifier

State Registrar

SEP 0 7 2012



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Physician/ Barbara S. Powell September 10:07P <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13404 Valley Drive Montgomery Rockville . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Days Hours (Month, Day, Year) 578-34-8646 Director 1 🗆 M 2 🗓 F 82 Sept. 25, 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 tx Yes 2 ☐ No Maryland | Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13404 Valley Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ Commercial the Business Woman Real Estate Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Senge Lillian Hockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Powell-Fritz/Daughter 613 Glen Echo Road, Frederick, Maryland 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cometery crematory or other place Resthaven Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10, 2012 Frederick, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 36 M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1 Onset and Death Physiciani Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) detached 9 Unknown is certificate has been signed by a director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 24 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 54 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🕅 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA ne Hospital or Attending Physin 24 hours after death.

Funeral Director: After this optically filled in by the funeral dis 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certific 29c. License numbe D43083 September 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Drive, #4200, Bethesda, Maryland George Sotos, M.D. 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marvin Parle September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Potomac Montgomery Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 096-12-1361 Director 1 X M 2 □ F 90 August 24, 1922 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10008 Broad Street 20814 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give ₩₩ T 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced WWII Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mentail I Important: If item 27 is marked or any injury or other traumatic ever nd Mental F marked o မ Samue1 Perlstein Frieda Effenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth K. Schmitz / Daughter 6109 Rudyard Drive, Bethesda, Maryland 20814 t of Healt : If item ? / or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date September 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 John 7. Khr MO1360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Advanced Age Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed ig physician and as the burial-transit Failure to Thrive that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No **ASSISTE** Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{X Other (Specify)} \) Living ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ne Hospital or Attending Phys n 24 hours after death. Ne Funeral Director: After this of pletely filled in by the funeral di 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🙋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0057456 September 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pinky Singh, MD 8218 Wisconsin Avenue, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Registrar Signatu State 7 2012 SEP 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28610 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 09 2012 John Joseph Porpora 5:07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign . Date of Birth **Funeral** Country) Maryland (Month Day Year) 18 1 M 2 □ F Director 218-30-5098 94 Yrs or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4102 Taylor Avenue, Apt. 316 21236 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 XYes 2 Mormy
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 XWidowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer Local Government n and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 Joseph Porpora Grace Dalfonzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace E. Kennedy / Daughter 212 Michael Place, Jerseyville, IL 62052 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State SEPTEMBER 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State cemetery, crematory or other place, 9/7/2012 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) INANATION Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical JOHN PORPORA as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year page 2 should be detached Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 X N 1 🗌 Yes funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After t Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

MORGAN,

2300 DULANEY VALLEY RD.

3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	-	partment of ertificate of		Mental Hy	giene Reg. No. 20	12 28611
	sicia	1/	1. Decedent's Name (First, Middle, Last)  ROGER PALME	R			2. Date of De	eath	3. Time of Death
	/ledic amine		4a. Facility Name (if not institution, give street and number)			or Location of Dea		4c. County of	f Death
Fun	eral		Manor Care Potomac  5. Social Security Number   6, Sex   7. Age	e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hr		Montgo	9. Birthplace (State or Foreign
Dire	_		228-60-6634 1/2 M 2 D F	67 Yrs	Months Days	Hours Mir	Mar. 26	7945 I	Kentucky
and s <b>how</b>	t at	ō	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
Maryl 28a-f	otified	Director	MD Montgomery	Potoma					1 ☐ Yes 2 X No
vith the	st be r		10e. Street and Number 11415 Glen Road		10f. Zip Code 2085	54		10g. Citizen of Wh	at Country?
death v	ier mu	- 1	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 1	Was Decedent of I If Yes, specify Cub			14. Race -	- American Indian,
Naryland 21215-0036  should be filed within 72 hours after death with the Maryland and Mental Hygiene. r is marked other than "natural", or items 23a or 28a-f show	xamir	d by	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🗔 If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🔀 No		rio riiodii, oto.,	Specific	White, etc. White
5-00 2 hours "natur	dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occu	pation	orkina	16b. Kind of Busi	
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hyglene. 27 is marked other than "natural", o	event, 1	B B	17. Father's Name (First, Middle, Last)		<u> </u>	18. Mother's N	ame (First, Middle,	, Maiden Surname)	
ryla	natic	욘	Ernest C. Palmer	T		<u> </u>	Fitzwate		
Ma 12 sho alth and 27 is 1	r traur		19a. Informant's Name/Relationship (Type, Print)  Betty D. Palmer / wife	- 1	ailing Address <i>(Street</i> 115 Glen R				te, Zip Code)
Baltimore, Marylar permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked	or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State	20b. Place of Dis	sposition (Name of crematory or other pla	1	Date	1	City or Town, State
Itim nit. Pag artmeni ortant:	injury (		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Federal/Service Licensee		ourney Cre			Woodbin	
Depring Deprins Depring Depring Depring Depring Depring Depring Depring Deprin	any ir		The state of the s	M01651	22. Name and Addn Going Hom Beverly L	e Cremat . Heckro	ion Serv tte. P.A	ice, P.O. . Clarksv	Box 784 rille, MD 21029
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not e	enter the mode of dyi	ng, such as cardia	ac or respiratory ar	rrest,	Approximate Interval Between
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Exam			Sequentially list conditions, b. FA /	LURE	70 7	HRIVE	E,		
pe	sit	Examiner	if any, leading to immediate acause. Enter Underlying Cause (Disease or iinjury	a consequence of):					
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760 cate be executed physician and	the bur	edical	d						
		<u></u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		3 □ Ectopic pregnar			23d. Date	of delivery
Division of Vital Records, P.O. Box 68 tal or Attending Physician: The law requires that the death certifi rs after death.  In Director: After this certificate has been signed by the attending	ned for	Physician/M	in the past 12 months?  1  Yes 2 No 9 Unknown  1 Unknown		5 Other (specify)	icy		Mont	h Day Year
ords, P.O. Bover the state of the signed by	detacl	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in th	ne underlying cause g	iven in Part I.	23e. Did t	tobacco use contrib	ute to the cause of death?
ds, quires en sigr	ad bluc						. 1 🗆	Yes 2 □ No 3	Probably 4 Unknown
SCOF law re- has be	e 2 sho	Completed					24a, Was	psy pri	ere autopsy findings available or to completion of cause of ath?
/ital Reco sician: The Jaw I certificate has b	or, pag		25. Was case referred to medical		26. F	Place of Death (Ch	1 \(\sum \) Yes		Yes 2 Wo
of Vital F Physician: 1	Il direct	욘		ent 2 ER/Outpa	tient 3 DOA Ot	<u> </u>		dence 6  Other	(Specify)
In of ding P th. After t	funera	cate:	27. Manner of Death  Natural 5 Pending  Accident Investigation  28a. Date of inju  (Month, Day		y wor	ıryat rk? ∐Yes 2 ☐ No	28d. Describe	how injury occurred	
riSiO r Atten er deal rector:	by the	Certificate:	3 Suicide 6 Could not be		street, factory, office		28f. Location (		or Rural Route Number,
Division of Vital   To the Hospital or Attending Physician: \[ \] within 24 hours after death. To the Funeral Director: After this certifica	illed in				المرابع والمرابع والمرابع والمرابع				
n 24 ha	pleted	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of each only one) 3 Certifying Nurse Practioner: To the	kamination and/or in	vestigation, in my opin	ion, death occurre	d at the time, date a	and place, and due to	o the cause(s) and manner stated.
To the	E 03		29b. Signature and title of certifier	$\gamma \wedge$	29c. Licens	se number	.58	29d. Date signed (	Month, Day, Year)
			30. Name and address of person who completed cause of di	eath (Item 23a) (Tvp	e, Print)	000/9	C:	7/2/	1 %.
			29b. Signature and title of certifier  Prinkly Srage  30. Name and address of person who completed cause of dependence of the completed cause of the complete cause of the compl	8218	Wisco	NSIN A	V. SF.	505 BE	-INCOUNTY O
Re	Stat gistra		31. Date filed (Month, Day, Year) SFP 0 7 2012	r's Signature	arked				

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			101	ryland / Depa					2 28612		
			1 - State Registrar Certificate of Death Reg. No. 20								
ı	Physicia		1. Decedent's Name (First, Middle, Last)  Paul	I	erkins		2. Date of Death Septembe	er 3, 20	3. Time of Death		
	Medic Examir		4a. Facility Name (if not institution, give street and number)	1		Location of Death	рерсеши	12   9:45A M			
-parel			5816 Melville Road		S	ykesville			rroll		
	Funeral Director		5. Social Security Number  3.17-20 - 20.13  Usual Residence of Decedent  6. Sex  1 💥 M 2 🗆 F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan 27	ear)	Birthplace (State or Foreign Country) MD		
	and show i at	ö	10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits		
	Maryl. 28a-f otifiec	Director	MD Carroll	Sykesvill	e				1 ☐ Yes 2 ☐ No		
	s 23a or	Funeral D	10e. Street and Number 5816 Melville Road		10f. Zip Code 21784		100	g. Citizen of What USA	Country?		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 ▼ Yes 2 □ N  If Yes, Give Year or Dates,	lo If		spanic Origin? (Spec n, Mexican, Puerto F Specify:		14. Race - Al Black, W Specify: W			
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ylan	d be fi Mental arked atic ev	은	Mifflin Thomas Perkins				ne Brown	on our amon			
, Maryland 21215-0036	nd 2 shoul saith and I n 27 is ma		19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia Perkins (spou	se)   19b. Mailing	g Address (Street a Melville	nd Number or Rural Rd., Syke	Route Number, Ci	ty or Town, State, MD 21784	Zip Code)		
Baltimore,	Page 1 ar nent of He ant: If iter iry or oth		20a. Method of Disposition  1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem All Count	atory or other place	9)	ے ا	c. Location - City Sykesvill			
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Licenste  Dua Hawk MC		Name and Address		GHT FUNER	RAL HOME ID 21784	& CHAPEL, PA		
ì	<b>3</b> -7-1		23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	he death. Do not enter					Approximate Interval Between		
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3876	rtificat ing ph e as th		IF FEMALE:								
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tiely filled in by the funeral director, page 2 should be detached for use as the burial-transitied.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
s, P.O.	requires that the der been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause give	en in Part I.		_	to the cause of death?		
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ono	ending sath. or: Aftu	ficat	1 ✓ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	M 1 🗆 Y	∕es 2 □ No					
Division of Vital Records,	ial or Attending P s after death. al Director: After t ed in by the funers	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, stree (Spec <i>ify)</i>	et, factory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,		
So the state of th								lace, and due to th	e cause(s) and manner stated.		
	To the within con the control		29b. Signature and title of certifier		29c. License			. Date signed (Mor			
			Cenyline			29085	2 2	epten	- 4 ZUIZ		
	51		30. Name and address of person who completed cause of dea	th (Item 23a) (Type, Pr.			_		2		
	Stat	-	31. Date filed (Month, Day, Year) 32. Registrar's		0 000	Cour	160	-o <sub>A</sub>	21137		
	Registra	ir	SEP 0 7 2012 / Lucius	A book	11						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28613 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month and stoll 2012 BESSIE RUBINSTEIN ectember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner م کنار N/A 101 If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 215-16-2190 1 □ M 2 🗓 F 91 12/25/1920 MD item 27 is marked other than "natural", or items 23a or 28a f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6408 ELRAY DRIVE, APT. C 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 ☑ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4 or 5+) 12 SUPERVISOR ADMINISTRATION Be timore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 9 LEVIN MARY LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACOB RUBINSTEIN/SON 902 WINDSOR ROAD, BALTIMORE, permit. Page 1 and ; Department of Healt Important: If item 2 any Injury or other t 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State CHEVRA AHAVAS CHESED : 09/06/2012 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD Balt 21. Signature of Funeral Service Livensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ + munth resulting in death) Medical Due to (or as a consequence of): Examiner with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) sician and burial-tran: Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 ed by the attending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 I Inknown 9 Unknown <u>P</u> signed by tid be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The After this certificate 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 W No ပ္ 1 DOA Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Pay, Year) SEP 0 7 2012

DHMH 17 Rev 06-2011

State Registrar

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32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Brooklyn Park Examiner 4c. County of Death Anne Arundel 113 Hammonds Lane . Social Security Number 212–58–6345 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9/30/51 Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Min 1 0 M 2 D F Director 60 Yrs MD irai", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Brooklyn Park MD 1 🗆 Yes 2 🗗 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 113 Hammonds Lane 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 K Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary C. Blinkey marked o ည Framcis W. Rykowski eq pinous Health and N 19a. Informant's Name/Relationship (Type, Print)
Roberta L. Rykowski /Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Hammonds Lane, Brooklyn Park MD 21225 Page 1 end 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cremation Center of MD 1 Burial 2 X Cremation 3 Removal from State 8/5/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. <sup>22</sup>, Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Doda Dice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Physician/ OVASCUL DI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Dire to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death' 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Residence 6 D Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Descritifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 18 30. Name and address of person of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RO Physician/ OUNG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COUNTU HOWARD GENERAL (DLUMBIA If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) (Month, Day, Year) Jan. 27, 1929 83 Director 216-84-6692 1 XM 2 □ F Ji Pyung, Korea Page 1 and 2 should be filed within recovery.

ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show

tant: If item 27 is marked other than "hatural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard County 1 Yes 2 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9895 Palace Hall Drive Apt.225 20723 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Korean 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Store Owner Carry-Out Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Soo Uk Ro Keum Boon Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr.Jin Young Ro,Ph.D. (Son) 7665 President Street Fulton, Maryland 20755 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Baltimore County) Friday, Sept.07,2012 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney varriey wellorial Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Si 22. Name and Address of Facility Services Funeral and Cremation Center, P.A. 21092-2215 Lic. #M00677 2325 York Road Timonium, Maryland 23a. Pert 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and dbe detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 □ Probably 4 □ Unknown cate has been sig 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital မြ 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calculated. cal 29a. Certifie Medic (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sigi ture and title of

クレ

State Registrar 30. Name

address of pe

Date filed (Month, Day, Year) 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#1/perFH, G932, IU/3/2012, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 3, 2012 11:45 AM Calavia Rucker Opal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Genesis Healthcare Rockville Rockville 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 - M 2XXF Days Hours Min (Month, Day, Yearch 24 **Director** Florida 43-18-1902 March Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Potomac 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 1703 Crestview Dr. 20854 United States items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō 9 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. Completed 3XXWidowed 4 ☐ Divorced **Black** event, the Medical 15. Decedent's Education (Specify only highest grade completed) . Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Seamstress Garment Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jackson Lelia Theresa Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Yvonne R. Paretzky / Daughter 1703 Crestview Dr., Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4XX Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 09/07/2012 Bethesda, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ CARDIOPULMONARY ARREST Medical resulting in death) Due to (or as a consequence of) Examiner MYASTHEMIA GRAVIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes XX No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>و</u> 1 Yes 2 No 3 Probably Y Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 🗆 No 1 Yes Yes 2 V No director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4XXNursing Home 5 - Residence 6 - Other (Specify) 1 Tyes 2 😾 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide M 1 Yes 2 No Investigation the 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

sician and burial-transit physician the burial Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the a d be detached for certificate this After 24 hours after death. Funeral Director: A completed filled in by within 2 To the I

with 1

72 hours after death

Baltimore, Maryland 21215-0036

State

Registrar

Medical

4 Homicide

29a. Certifier

(Check

3 [

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 SHADY GROVE RD., ROCKVILLE, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

SEPTEMBER 6, 2012

29c. License number

D67092

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

WEIHAN WANG, M.D.,

determined

. Date filed (Month, Day, Year, 32. Registrar's Signatur SEP 0-7-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 7, per fh, g931 9-14-12 sm
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2,2012 Physician/ Janice Marie Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10200 Ridgemoor Dr. Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 Months Hours Director 68 084-32-7061 69 Pennsylvania June 6. 1943 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10200 Ridgemoor Dr. 20901 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 ☐ Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Priest Church / Clergy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Calvin Robinson Leola 0dessa Edwards 1 and 2 should be the street of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berit M. Lakey / Partner 10200 Ridgemoor Dr., Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Durial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 09/06/2012 Beltsville, MD 21. Signature of Funeral Service Lices <sup>22</sup>Rapp Funeral and Cremation Services M00382 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition OVARIAN CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** METASTATIC BREAST CANCER Sequentially list conditions, Examine trany, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for self-consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) /sician al e burial-t Division of Vital Records, P.O. Box 68760 Physician/Medical phy: the attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a d be detached f Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate ha lirector, page 2 performed? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes မ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantioner: To the best of the wiledge death onner distributions. Onto and plane, and due to the course(s) and Transpires state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44883 SEPTEMBER 4, 2012 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THUAN-HOA NGUYEN, M.D., 12201 PLUM ORCHARD DR., SILVER SPRING, MD

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29 20°1°2 12:40 Am William Robinson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. Country) unk **Director** 221-28-2858 1 2 M 2 D F 63 15, shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince Georges Capital Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5256 57th Avenue 20743 USA unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?unk 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) unk unk ge 1 and 2 should be filed wit nt of Health and Mental Hygie t: If item 27 is marked other i or other traumatic event, the Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Ave; Takoma Park, MD 20912 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 112 State cemetery, crematory or other place, 21. Signature Funeral Service Lights 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease shack, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TASTATIC Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ☐ Pregnam.
☐ Unknown Pregnant at time of death the ; 9 Unknown ed by ti been signed is should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗓 No မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated to the cause (s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place are the time, date are the time, 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325A HARROVE ARKWAY GREGORBELT 31. Date filed (Month State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BENZ 8:30 AM Margaret Ann Radecke Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death US-125 ROSPITUTE BULTI MORS Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Director 219-22-8517 83 1 M 2 🔀 F 1/25/1929 Baltimore, MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 908 Palladi Dr. should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Telecommunication Dispatch Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Sydney Millman Loretta Katherine Flannery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Ridge Rd., Catonsville, MD 21228 it of Health a Mary Beth Wireman Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 9/7/2012 New Cathedral Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Far ral Service Deenses 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line rval Between Diset and Death Immediate Cause (Final Physician 212932 SEVERE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DIFFICILE JHFECTION UNKNOWN CLOSTRIBLUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury work Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the F 29c, License number 6060105 lucion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURTILLES UD Ausores 1 HERZSON MUS 900 5 CHTON

State Registrar 31. Date filed (Month, Day,

ADE

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S AR

12-06617 Monique Ragin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physic		1- For State Registrar	Certificate		,,,	Reg. No. 20	2 286
al Exam		Decedent's Name (First, Middle,Last)	Ragin	<u> </u>	2. Date of D Month	110g. 110.	3. Time of Death 0000 hrs
ai Laaii	IIIG	4a. Facility Name (if not institution, give street and number)	-	4b. City, Town, or Locat		oer 2, 2012 4c. County of Deat	
		Johns Hopkins Hospital		Baltimore			
Funeral Director		212-02-4061 1_M 2KF	ge (In yrs. last birthday)		ours Min.	Birth (MM/DD/YYYY) 9. Bi Forei 11,1981 <sup>Co</sup>	rthplace (State or gn <sup>Duntry)</sup> MD
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limit
	<u> </u>	MD	Ba.	ltimore			1 Yes 2 N
Maryland 28a-f show d at once,	Director	10e. Street and Number		10f Zin Code	213	10g. Citizen of What Cou	intry?
with the Maryland us 23a or 28a-f sho he notified at once,	E D	2105 E. Oliver St.		-21:	212	USA	
items ust he	Funeral	11. Marital Status 12. Was Decedent 1 Never Married 2 Married Armed Forces	?	Was Decedent of Hispanic If Yes, specify Cuban, Mexi		14. Race - Amei White, etc.	rican Indian, Black,
after d	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No 1	Yes 2 No spe	cify:	Specify: Bla	ack
natur Exam	ted	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or	during	dent's Usual Occupation (G most of working life. DO N		16b. Kind of Business/ Baltimon	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Department of Health and Mental Hygient and in the 23a or 28a-f she Important! If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	12th	·	cher's Aide	9	Public S	
Hygier	S	17. Father's Name (First, Middle, Last)  James Ragin			ther's Name (First, Middle	, Maiden Surname)	
ild be t Mental narked event,	To Be	19a. Informant's Name/Relationship (Type, Print )	19h Maii	ling Address (Street and I	Pauline Wa		- Zin Codo)
2 shouth and 27 is numeric	-	Pauline Wardlow (moth	100	05 E. Olive			
s l and of Healt of item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta	20b. Place of Disp	osition (Name of cemetery	, Date	20c. Location - City or	Town, State
ment crant		4 Donation 5 Other Specify:	Trinity	Cem.	Sept.11,	2012 Balti	.more,MD
permit Depari Impo		21. Signature of Funeral Service Licensee	22 C	Name and Address of Fa	Scruggs Fu	neral Home	<u> </u>
ysician		2sa. Part I. Enter the disease, or complications that saused failure. List only one cause on each line.	the death. Do not ente	r the mode of dying, such a	ston St as cardiac or respiratory a	Peat to Md.	Approximate Interva
Medical aminer		Immediate Cause (Final disease a.	ASTHM	IA			Between Onset and Death
		or condition resulting in death)  Due to (or as a conse	equence of);				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):			-	
	Examiner	(Dispass or Injury that initiated events resulting in death) Last	equence of):				
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te be e nysiciar burial	Medical	ZUZZET TENE	ne of pregnancy	931 9-7-12	ντ 	23d. Date of deliver	
eath certificate be executed attending physician and for use as the burial - transit	cian/N	23b. Was decedent pregnant in the past 12 months?	2 🗸 F	Fetal death 3 🗸 Ect	opic pregnancy		/ Day Year
death c le atten I for us	Physic	1 ✓ Yes 2 No 9 Unknown 9 Unknown	time of death 5	Other (Specify)			
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law rec has bee 2 shou	Completed				24a. Was auto		topsy findings available completion of cause of
		25. Was case referred to medical		26 Plane of Day	1 ✔ Yes	2 No 1 ✓ Ye	es 2 No
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ysiciani: 1 ne his certificate director, page		27. Manner of Death 28a. Date of Inju	ry 28b. Time of ear)		_	how injury occurred	
After this certificate funeral director, page	Ţ.	A_A Natural 5 Pending	1	1 Yes 2			
Attending ruysician: The r death.  ector: After this certificate by the funeral director, page	cation: T	2 Accident Investigation	Line At harman for	eer, ractory, office building		(Street and Number or Ru State)	rai Route Number, City
na or attending ruysician; the are after death.  ral Director: After this certificate led in by the funeral director, page	ertification: T	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	jury - At home, farm, str	,,,	or Town,	o.u.o,	, , , , , ,
1 to spiral or Attending Prysician: Ine 24 hours after death.  Funeral Director: After this certificate rely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Inj (Specify) 29a. Certifier (Check only 1 CertifyIng Physician: To the best of my	/ knowledge, death occ	urred at the time, date and	place, and due to the cau	ise(s) and manner as state	ed.
10 the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 6 Could not be determined (Specify)  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manyler stated.	/ knowledge, death occ	urred at the time, date and ation, in my opinion, death	place, and due to the cau	ise(s) and manner as state and place, and due to the	ed. e cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical Certification:	2 Accident 3 Suicide 6 Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my one)  2 Medical Examiner: On the basis of examiner:	/ knowledge, death occ	urred at the time, date and lation, in my opinion, death	place, and due to the cau	use(s) and manner as state e and place, and due to the 29d. Date signed (Mor	ed. e cause(s) oth, Day,Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nelson Ross Month 08 28<sup>Day</sup> 2012 Medical 3:23 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8225 Coatsbridge Court Severn Anne Arundel Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth 219-48-8095 Months Days Hours Min (Month, Day, Year) 07/12/1947 **Director** 1 X M 2 D F Maryland 65 Yrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severn 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8225 Coatsbridge Court 21144 USA or items of Health and Mental Hygiene.
item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner I 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 10th Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ross Helen Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s nt of Health a Lolita Ross (Wife) 8225 Coatsbridge Court, Severn MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Mem. Pk. 4 Donation 5 Other (Specify) 9/5/2012 Waldorf, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Tri-State Funeral Services, Inc. 814 Upshur Street NW, Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) U1)9 CONCOR SMOULE Medical Due to (or as a nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has performe 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗙 No Other: <u>မ</u> 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 00064648 September, 4,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maisa Monephash, 3333 N. (CUV) + st Swite 107, Baltimore, MD 21218 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene									
		Reg. No. 2  1. Decedent's Name (First, Middle, Last)  2. Date of Death								
	Physicia Medi		William J. Rhoads		Sept. 03, 2012 3. Time of Death					
1	Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
			Holy Cross Hospital	Silver Spring	Montgomery					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 175–18–7414 1 ▼ M 2 □ F 93 Vrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country)					
		1	175–18–7414 Usual Residence of Decedent 1 ★M 2 □ F 93 Yrs.		April 24,1919 Pennsylvania					
	yland f sho	호	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits					
	e Mar 28a- notifie	iř	MD Prince George's Silver S		1 ☐ Yes 2 💆 No					
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 3160 Gracefield Road #E2107	10f. Zip Code 20904	10g. Citizen of What Country?  USA					
	eath v	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Speci	fy Ves or No-					
36	hours after death natural", or items lical Examiner m		1 Never Married 2 Married 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Ri  1 Yes 2 No Specify:	can, etc.) Black, White, etc.					
8	ours a	Completed	3X Widowed 4 □ Divorced If Yes, Give Year or Dates.1944-46		<sup>Specify</sup> White					
75	an "na Medic	ldm	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry					
212	within giene er tha	Ö	Lientendary (0-12) College (1-4 of 5+)	cronics Technician	Federal Government					
pu	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Maiden Surname)					
yla	should be filed vand Mental Hyg ris marked othe raumatic event,	မ	John Howard Rhoads	Daisy Wer	ner					
Maryland 21215-0036	2 shou th and 27 is m traum		l		Route Number, City or Town, State, Zip Code)					
	f Heal f Heal item		David Rhoads / son 7309 20a. Method of Disposition 20b. Place of Disp	Oskaloosa Dr. Derwoosition (Name of Da	· 1					
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 D Burial 2 X Cremation 3 D Removal from State cemetery, cre	matory or other place) urney Crematory 9/8/						
alti	sparting porta		E THAT OOL							
<u>m</u>	9 9 E E O		Melwitz M01651	Severly L. Heckrotte	Service P.O. Box 784 P.A. Clarksville, MD 21029					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	espiratory arrest, Approximate Interval Between					
-	Physician Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocardial	Infarction	Onset and Death					
	Examiner		Due to (or as a consequence of):							
	2	ner	Sequentially list conditions, it arry, leading to inductate cause. Enter Underlying							
	outed nd ransit	Examiner	Cause (Disease or injury that initiated events c.							
	be executed sician and burial-transit	al E	resulting in death) Last Due to (or as a consequence of):							
09/	the the	edical	d							
687	eath certifica attending p	Ň/Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							
Вох	e atter	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ Yes 2 ☐ No  1 ☐ Yes 2 ☐ No	Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year					
O. E	that the deaned by the setached	hys	9 🗆 Unknown 9 🗆 Unknown							
P.O.	s that gned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
rds	requires the been signer should be a	ted	Colon Cancer Metastatic		1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown					
of Vital Records,	has b	Completed	Acute Renal Failure		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of					
H.	ician: The la certificate ha rector, page		25. Was case referred to medical		performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No					
/ita	ysician: s certific director,	8	examiner?	26. Place of Death (Check or Other:	<u> </u>					
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ا	oital o urs af ral Di				City or Town, State)					
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	Medical	29a. Certifier (Check Check Ch	tigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s) and manner stated					
	To the within To the comple		only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	29c License number	and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)					
			Indiew fundation	D0036716	9/4/12					
X	\		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)						
1			Andrew Kundrat, M.D. 3110 Gracefield 31. Date filed (Month, Day, Year) 32. Phoistrar's Signature		g, MD 20904					
	Stat Registra	-	31. Date filed (Month, Day, Year) SEP 0 7 2012  32. Pegistrar's Signature	and						
DHM	MH 17 Rev 06-2		Amil A . mare   Marie - 1							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 28623 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 2, 2012 Physician/ 8:44A Marie Louise Rehm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard 13010 State Route 108 Clarksville 8. Date of Birth (Month, Day, Year) Aug 4, 1938 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Davs Hours **Director** 218-66-1516 1 □ M 2 🗶 F 74 Yrs. Germany Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No MD Howard Clarksville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13010 State Route 108 21029 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 XMarried permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. ģ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X ☐ No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Catering Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clara Guenttener Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adolf J. Rehm 13010 State Route 108, Clarksville, MD 21029 (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State All County Cremation 9/7/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatine of Funeral Service Licens 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ AMYOTROPHU Medical Due to (or as a consequence of) **Examiner** fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year detached the g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 🗆 Yes 2 🗆 No this certificate Yes 2 4 No 24 hours after death.

Funeral Director: After this certifica etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie ٥ 72594 SIENTEM BER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Evelvn Jackson

7 2012

31. Date filed (Month, Day, Year)

3416 Olandwood Court Ste: 200 Olney, MD, 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28624 Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Septemb. Year William В. 6:30PM Rund 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital Baltimore lt more . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8 Date of Birth Funeral Months Hours (Month, Day, Year) 219-36-0787 Director 1 🗓 M 2 🗆 F 71 William Rund Dec 31 1940 MD Usual Residence of Decedent ir than "natural", or items 23a or 28e-f show the Madical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3914 Nemo Road 21133 USA 11 Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces permit. Page 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or is any injury or other treumetic event, the M-sice Examinations. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1968 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Specify white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) grocery meat cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Rund Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Ellen Rund (spouse) 3914 Nemo Rd., Randallstown. MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 9-8-12 4 Donation 5 Other (Specify) Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel . Signature of Funeral Service Licensee Paige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) utra channal Medical Due to (or as a consequence of) Examiner Oycars thepertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to ( r as a consequence of) sicien and burlal-trensit Hospital or Attanding Physician: The lew requires thet the death certificete be executad that initiated events resulting in death) Last Due to (or as a consequence of): the ettending physicien hed for use es the burla Physician/Medical 68760 LIF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery P.O. Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🐼 No 5 ☐ Other (specify) Pregnant at time of death Month Day Year signed by the e 1 ☐ Yes 2 ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attanding Physician: The lew requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should to 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed<sup>4</sup> Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 1105 PLC 1 Yes 2 No ဂ 1 M Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Matural work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 29b. Signature and title of certifier RES September 4 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oi Hospital of Baltimore 2401 W. Belvedere Ave, Baltimore 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SAUL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Seasons Hospice at Northwest Hospita Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12/24/30 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-26-0858 Days Hours Min Director 1 🗆 M 2 🕱 F MD Usual Residence of Decedent items 23a or 28a-f short death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8001 Middlebury Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Elevator Company Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert Smith Mary Ellen Frank 19a. Informant's Name/Relationship (Type, Print) ab. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1349 Poplar Hill Drive, Annapolis MD 21409 Sharon Lee Kraft /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 9/10/12 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda Name and Address of Facility Narles L. Stevens Funeral Home, 1 501 E. Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death inc. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Uisease o injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 🔀 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending work? 2 🗀 No To the Hospital or Attend within 24 hours after death To the Funeral Director: Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 60 (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28626 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $\overset{\mathsf{Month}}{AUG}$ 2012 9:35 a<sup>M</sup> CHRISTEL SORRELL Medical 4a. Facility Name (if not institution, give street and number) WALTER REED 4b. City, Town, or Location of Death Examiner 4c. County of Death BETHESDA MONTGOMERY NATIONAL MILITARY MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs, 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 577-64<del>-</del>7874 1 M 2 X F Feb. 2, 1932 GERMANY Usual Residence of Decedent or then "natural", or itams 23e or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No PRINCE GEORGE'S Capitol Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7303 Joplin St. 20743 GERMANY 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Mamied 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 XWidowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiana. Elementary/Secondary (0-12) 12TH College (1-4 or 5+) PRIVATE HOSTESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba fila and Mantal F is marked of JOHANN TAMBUR HELEN KRONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Haalth a item 27 is NATHAN ATKINS/FRIEND 7303 JOPLIN ST. CAPITOL HEIGHTS, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Paga 1 a Dapartmant of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CEMETERY 9/18/2012 ARLINGTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. THE 7474 Landover Rd. Hyattsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of Examiner AORTIC STENOSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of physiclan and s tha burlel-trans CHRONIC RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): I or Attending Physicien: The law requiras that tha daath certificata ba axe aftar daath.

Diractor: Aftar this cartificata has baan signed by tha attanding physician a d in by tha tunaral diractor, paga 2 should ba datachad for use as tha burlel-Physician/Medical P.O. Box 68760 IF FFMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year Part **II. Other signific**ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours aft To the Funeral Dis complately fillad in Medical 1 [XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 [Image: Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) AUG 23 2012 D45548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER

DHMH 17 Rev 06-2011

State Registrar CATHLEEN N. CLANCY, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

BETHESDA, MD 20889

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28628 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 04, Physician/ 2012 Dorothea A. Svilar 12:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Oak Crest Village Care Center Parkville . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, n yrs **92** 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Flushing, New York 103-10-6013 **Director** February 6, Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits at Director notified a Parkville 28a-f Maryland Baltimore 1 Yes 2 XXVo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r by Funeral United States 21234 8832 Walther Blvd. Apt. 323 South items permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner mu
once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Force 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk. Adeline Agusta ൧ Otto Langbehn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Kathryn Svilar (Daughter) 106 East 27th Street Cheyenne, Wyoming 82001 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Evans Funeral Chapel Bel 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State September 05, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) ☐ Pregnant
☐ Unknown detached s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ofibb, PVO: 720m 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident after death Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29d. Date signed (Month, Day, Year) 2012 eted cause of death (Item 23a) (Type, Print) CLNY 8800 WOHN& Blvd , ParKville MO 21234

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Phyllis Kathryn Stanley 20°I°2 4:35 AMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care, Inc. Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Days Hours 216-24-7576 Director 1 □ M 2 🖾 F Dec 10, 1927 West Virginia Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🖾 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 306 Kimrick Place 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) self employed insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Bynion Margaret Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Kimrick Place; Lutherville, MD 21093 William Stanley - husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ other (Specify) 177 State cemetery, crematory or other place of Francial Service Liber 22. Name and Address of Facility State Anatomy Board 21. Signature 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ementa AIZHCIMER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Day Month Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by andiomy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature and title of certifier ptember 3,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 N. Charles ST TUDSON MY

State Registrar 31. Date filed (Month, De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEBASTIAO AUGUST GILBERTO Μ. 20°11°2 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE Examiner 4b. City, Town, or Location of Death TOWSON GILCHRIST HOSPICE CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min 082-64-8440 Director 1 🔀 M 2 🗆 F 50 Yrs PORTUGAL 8-29-1962 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show eny injury or other treumatic event, the Marial Examination using a page. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ROSEDALE MD BALTIMORE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21237 7628 PHILADELPHIA ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: PORTUGUESE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 TRANSMISSION TECHNICIAN GENERAL MOTORS Be 18. Mother's Name (First, Middle, Maiden Surname) ROSA CARR 17. Father's Name (First, Middle, Last) MANUEL **SEBASTIAO** ည CABRITA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7628 PHILADELPHIA RD ROSEDALE, MD 21237 7628 PHILADELPHIA RD ELSA M. SEBASTIAO/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-1-2012 BALTIMORE, MD CARDENS OF FAITH CEMETERY 4 Donation 5 Cother (Specify) FNIMBMENT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Non Immediate Cause (Final Physician -small disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerei Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPILL ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) anno 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Tavson un 6701 N Chancia MANUES AMON 31. Date filed (Month, Day, Year) State SEP 07 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOROTHY FREDERICKA SMITH SPIEMER 2012 12:20 AM Medical 4a Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE CENTER TIMONIUM BALTIMORE 5. Social Security Number 20am 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Months 220-03-8268 Director 1 □ M 2 🛣 F 92 Yrs 5-23-1920 MARYLAND Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 28a-f must be notified MD BATTIMORE **ESSEX** 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1644 FRENCHS AVENUE 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. o, Completed by 1 Never Married 2 Married Yes Yes, Give 2X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3X Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) TIER **ESSKAY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ LOUIS **KREBS** CHRISTINA BURKHART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA THIVERGE/DAUGHTER 1644 FRENCHS AVE ESSEX. MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 9-6-2012 BALTIMORE, Signature of Funeral Service Licensee FUNERAL HOME MD 21237 22. Name and Address of Facility CVACH/ROSEDALE 1211 CHESACO AVE ROSEDALE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph\_sician/ Onset and Death SUBBURAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Such to lor an a nontricement of resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director name Be Was case referred to medical 26. Place of Death (Check only one) exammer? 2 No ၉ 4 Nursing Home 5 Residence 6 N Other (Specify OSPICE) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural
2 Accident 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 XNo 28 5:00 am OUT OF Investigation FELL Guicide 6 Could not be Injury - At home, farm, street, factory, office, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined 1813 EASTERNAVE ESSEX MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature an 29d. Date signed (Month, Day, Year) 2300

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28632 Certificate of Death Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HI Simplins victoria 2017 91. 20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year, Min Director 219-98-1726 1 M 2 TF Maryland 30 15, 1982 June or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Warwickshire Lane Apt. F 21226 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, \$ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 9th N/A Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be file alth and Mental h ၉ Roger L. Simpkins Linda J. Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Linda J. Stevens/ Mother 3715 Bel Air, Rd., 1st Floor, Baltimore, Maryland 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Atlantic Crematory Sept.6,2012 Glen Burnie, Maryland 21. Signal of Fineral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME OF LANSDOWNE 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage LIVER DIJEGH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) detached the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, 8 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other:
4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun Natural 5 Pending Accident Investigation 6 ☐ Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5703 Baltimore MDZ1209 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSILajapaksenin Smith

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Charles Strauss 3) 2012 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Garre memorial Hasorks Jakland 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 1 ☐ M 2 ☐ F If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9/22/1952 5. Social Security Number **Funeral** Min. Months Days Hours 213-64-0437 59 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be with a once. 1 Yes 2 XNo Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 119 Glenwood Ave. 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Information Systems/Lab Tech Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Franklin Strauss Irene Stephan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne Marie Strauss 119 Glenwood Ave., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 9/6/2012 Violetville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home 21. Signature of Fundamental Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Auterio Scienotic woon they vacabandina **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f P.0. 1 □Yes 2 □No 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ icate has been significate has been significated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The certificate I 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check onl. one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No 2☐ ER/Outpatient 3☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed

2014 Acres Drive Oaklav Danie

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 1 perpHYS G932 10/19/2012 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Geralyn Jo Physician/ Şabyan 9:00 AM 2012 eptember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Liberia (Month, Day, Year) 05/16/1960 1 □ M 2 □XF Months Days Hours Min 474-82-7850 Director 52 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD 1 XYes 2 No Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17467 Miller Sawmill Road, Apt. B 21782 death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 Nair Fo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc δ 1 Never Married 2 Married 2 □ Mair Force Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Det artment of Health and Mental Hyglene. Important: If item 27 is marked other than "amp injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) Satelite Technician Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Sabyan Norma Fann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael John Woodcock / Son 19513 Transhire Road, Montgomery Village, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/6/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 6 Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEVMONIK disease or condition resulting in death) 2WDAY Medical Due to (or as a consequence of): Examiner CERRBORS VASCULAR Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MTPERTENSION 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 1 Horsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4,2012 wa mo 7)08)0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) treet Hagerstown, MD 21740 301-739-7100 340 MILL S Dr. Vasant Datto 31. Date filed (Month, Day, Year) State 7 2012 SEP 0 Registrar

DHMH 17 Rev 7/2009

SABYAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Barbara Ann Saunders 1447 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A**Examiner** 4b. City, Town, or Location of Death Maryland 7. Age (In yrs. last birthday) Boltimo eneral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 217-64-6011 Hours Min 1 🗆 M 2 🕇 F Director 12/24/1953 58 Maryland Usual Residence of Decede 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XYes 2 No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 401 N. Eutaw St. #109 21201 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc ō þ 1 Never Married 2 Married Yes 2 XNo Yes, Give 1 ☐ Yes 2 X No Specify: "natural". Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Mountain Manor I Hygiene. Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Dietary Treatment Center other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Matthew Saunders Katherine Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau Katherine Saunders (Mother) 3707 Chesholm Rd., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 9-5-12 on-site Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Higheral Service Lices 2765ephd # Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Phylician disease or condition resulting in death) Medical Due to (or a a consequence of) **Examiner** Septic Shock Sequentially list conditions cause (Disease or injury Due to for as a consequence of, Exami physician and the burial-transit patic Failure that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Immunode ficiency as IF FEMALE: esn 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 1 Yes 2 9 Unknown the 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Chronic Kidney Disease 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performed? this certificate 2 🖸 No Yes 2 N 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending Accident М 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Maryland 21215-0036 Baltimore, Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director; Af
completely filled in by the fu Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 8972 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 Manyland Ahmad General 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar SEP 0.7 DHMH 17 Rev 06-2011

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State of Maryland / Department of Health and Mental Hydiene

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and I	Examin	er	4a. Facility Name (if not institution,	,			4b. City, Town, o				4	c. County o			
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_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying F	Physician: To the best of m	y knowled	ge, death o	ccurred at the time	, date and p	place, and	due to the ca	iuse(s) a	nd manner	as stated		
	the H nin 24 the Fi	Me	only one) 3 L Certifying N	aminer: On the basis of exa lurse Practitioner: To the I	best of my k	knowledge, (	death occurred at th	ne time, date	and place	e, and due to the	ne cause	e(s) and man	ner as sta	ited.	
	co de it		29b. Signature and title of certifier	1			29c. License	number			29d. Da	te signed (A	Nonth, Da	y, Year)	
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_			30 Name and address of person who william lan	no completed cause of dee MD 1649	ath (Item 23	Ba) (Type, Pr	int) Rd E	Idon	sbu.	S M	0	2178	94		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28638 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 5. 2012 12:35 A M Sarah Bailev Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 579-42-7038 1 □ M 2 🏋 F Director July 25, 1914 Virginia 98 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hyglene. The state of Health end Mental Hyglene. That if if item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔯 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 8810 Walther Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Health Education Lung Association Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Bailey Henrietta Friend Line 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd. #3105; Baltimore, MD 21234 Robert Richard Smith / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) DateUNk. 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, VA 21. Signature of Juneral Service 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson. 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one laure on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke wecks disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ele 4 rovascular Sequentially list conditions, if any, leading to immediate cause. Finter Underlying Examine nding physician end use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ antery disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 № No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be An 24 hous.
The Funeral Directory filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in my action in the cause of examination and/or inventioning in my action. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29d. Date signed (Month, Day, Year) September 5 2012 29b. Signature and title of certifier randurs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 ours M N. Chazles ST TONSON MAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06568 2012 28639 State of Maryland / Department of Health and Mental Hygiene Oakley Savage, Jr. 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Oakley Savage, Jr. Month 1315 hrs August 31, 2012 Medical Examiner County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 820 South Caton Avenue Apartment 2G 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 8 / 16 / 53 Foreign MD If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 213-62-2680 Months Hours Min Director 1 X M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore MD N/A Yes 2 No altimore, MD 21215-0036
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portant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at once. Directo 10g. Citizen of What Country?
USA 10e. Street and Number 820 S. C Caton Ave - 2G Funeral 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Africaner. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 No specify: ð 16a, Decedent's Usual Dccupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) National Wire Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Electrical Wiring 7. Father's Name (First, Middle, Last)
Oakley Savage, Sr. 18.Mother's Name (First, Middle, Maiden Surname) Elizabeth Hutchinson Be 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5810 Arizona Ave, Balt., MD 21206 19a. Informant's Name/Relationship (Type, Print Oakley Savage, III/Son Date 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory 9/8/12 1 Burial 2 Cremation 3 Removal from State Balt., MD 4 Donation 45 Other Specify 22. Name and Address of Facility Hari P.Close F.Svs, PA 126 Belair Rd, Balt., MD 21206-5105 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death HYPERTENSIVE CARDIOVASCULAR DISEASE Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exa and - transit Physician/Medical AMENDED this certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial UNPENDED Records, P.O. Box 68760, The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FFMALE: 23b. Was decedent pregnant in the Пау 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 V No 3 Probably 4 Unknown CIRRHOSIS OF THE LIVER, CHRONIC DRUG USE Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? ✓ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death in 24 hours after the Funeral Director: A' 1 X X Natural Division 1 Yes 2 No 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be determined To the Funcompletely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

& OGME

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Mary G. Ripple MD. De 31. Date filed (Month, Day Year) 7 2012

**ORIGINAL** 

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

person who completed cause of death (Item 23a)

32. Registrar's Signature

O.C.M.E.

September 1, 2012

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Βi Tunvi 10:53P<sup>M</sup> Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Year, 578-25-9032 **Director** 1 M 2 X F 44 April 22,1968 Cameroon 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 X Yes 2 □ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3550 Gentry Ridge Ct. 20904 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 K Never Married 2 Married δ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black 3 Divorced If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th LPN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Gweku Tunyi Tabita Nsose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health item 27 other tra Anguh John/Brother-Inlaw <u> 2316 Blue Valley Dr. Silver Spring, MD 20904</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place)
Gate of Heaven Cem. 09-15-2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Service Lice 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Rd. Hyattsville, MD 20785 23a. Part 1. Enter the disease, or conshock, or heart failure. List only , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician B disease or condition Medical resulting in death) Du to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: Tha law raquiras thet the daath cartificata be axecuted signed by tha attanding physiclan and d ba detachad for usa es tha burlal-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s cartificate has b diractor, paga 2 s Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical diractor, Be 26. Place of Death (Check only one) Hospital 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) |요 2 7 No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 27. Manner Life h Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Diractor: A 2 Accident
3 Suicide aftar death М 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aftar
To the Funaral Dirac
completaly filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

31. Date filed (Monti

completed cause of death (Item 23a) (Type, Print)

aistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Bertha Tabisz Laura 2:30 A M September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Min. (Month, Day, Year) Director 048-18-7963 85 1 🗆 M 2 🗓 F Sept 26,1926 Connecticut pernit, Page 1 and 2 should be filed within 72 hours arter death with the hours arter death with the hopertment of Health and Mental Hyglene, Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2XXNo Montgomery Silver Spring Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 United States 14716 Locustwood Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aniela Vondonkewicz Alexander Lukaszewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14716 Locustwood Lane, Silver Spring, MD 20905 Michael Tabisz - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) thed of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 9/7/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trensi that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a decu BINS Sacral 2 No 3 □ Probably 4 □ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ၉ 6 NOther (Specify) WOS Pice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 3 2012 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) DV TARON HALLES N 31. Date filed (Month, Day, Year, 32. Registrar's Signature Registrar

		Please	e Type or Print in						•	ole.
		For State	State of Marylan				Mental Hy	giene	9	10 0001
		Registrar		Cei	rtificate of	Death	1	Reg. N	o. 2U	12 28643
Physicia Medic			A, Thomas	5 51			2. Date of De Month		ay <b>4</b>	3. Time of Death
Examine	er	4a. Facility Name (if not institution, giv Upper Chesapeat		eter	4b. City, Town, o	or Location of Death	n	40	c. County of	Ford
Funeral Director		218-40-8516	Sex 7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth ay Year) 6	1942 N	9. Birthplace (State or Foreign Country) Mary Land
nd now at	ř	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
// Aarylar 8a-f sl	Funeral Director	Maryland Harford	_	onktor						1 🗆 Yes 2 🔽 No
the Na or 2	٥	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wh	nat Country?
th with ms 23 must	ıner	3810 Justin Road			21111				ted St	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 19 1	61-	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√☐No	Hispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Black,	American Indian, White, etc. White
5-0 5-0 2 hour "natu	plet	15. Decedent's (Specify only highest g	Education grade completed)	16a. Dece	dent's Usual Occup	pation during most of wor	rkina	16b. I	Kind of Busi	iness Industry
1121 ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired	ol Engine	•	Ba]	Ltimor	re County Gov.
d d d d d d d d d d d d d d d d d d d	Be	17. Father's Name (First, Middle, Last)		l		18. Mother's Nar				
ylar ylar d be f Menta arked	မ	Albert L. Thoma	as			Pear]	L LaChan	ice		
Mary Mary Pand Pand Pand Pand Tis m		19a. Informant's Name/Relationship (		1	= :	and Number or Ru				,
and 2		Kathryn F. Thomas  20a. Method of Disposition	<del></del>	<u>.                                      </u>	Justin R	oad Monk	cton, Ma			111 ity or Town, State
Baltimore, oernit. Page 1 and Department of Hee Important: If item any injury or othe proces.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Ced	ar Hil	natory or other pla 1 Cemete	ry Sept	8, 112	Broo	oklyn	Park, MD
Bal permi Depar Impor any ir		21. Signature of First ral Service Mcer	baugh	€v 3	2. Name and Addre ans Fune Newport	eral Chape Drive For	el & Cre rest Hil	mati	ion Se Maryla	ervice-BelAir and 21050
Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	<b>)</b> :			or respiratory a	rrest,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ		al inta	rction_				
300	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ	ence of):						
be executed ician and burial-transi	Exal	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):				-		
760 760 cate be physicis	edical	•	d						-	
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1  Live Birth 2  Feta 4  Pregnant at time of o	death 3	Ectopic pregnar Other (specify)	ncy			23d. Date Mont	of delivery h Day Year
P.O.	by Pi	Part II. Other significant conditions	contributing to death but not res	ulting in the ι	inderlying cause g	iven in Part I.	23e. Did	tobacco	use contrib	ute to the cause of death?
rds,	eted						1 🗆	Yes 2	2 □ No 3	Probably 4 Unknown
Recol	Completed						24a. Was auto perf 1 \(\sum \) Yes	psy orm <u>ed</u> ?	pri de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
sian:	Be (	25. Was case referred to medical examiner?				Place of Death (Che	ck only one)			
Physic all dire	: To Be (	1 Yes 2 Ho	Hospital:		nt 3 🗆 DOA		lome 5 Res			
ion of ion ion ion in the funeral ine funeral ion	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigativ 3 ☐ Suicide 6 ☐ Could not		28b. Time of injury	wor	ryat k? ]Yes 2 ☐ No	28d. Describe	how inju	ry occurred	
Divisation At aris after or all Direct lifed in by		4  Homicide determined	building, etc. (Specify	)			City or To	wn, State	e)	or Rural Route Number,
ne Hosp n 24 hor ne Fune pleted fi	Medical	(Check 2 ☐ Medical Exam	ysician: To the best of my knowl niner: On the basis of examination rse Practioner: To the best of my	and/or inves	tigation, in my opin	ion, death occurred	at the time, date	and place	e and due to	o the cause(s) and manner stated.
To the within routh com		29b. Signature and title of certifier	4 MD		29c. Licens				ate signed (	Month, Day, Year)
511		30. Name and address of person who	completed cause of death (Item	23a) (Type, F			11201	ДD	210	14
5)1 \ V	e	30. Name and address of person who  Joliz Ti-fev  31. Date filed (Month, Day, Year)  SEP 0 7 2012	32. Registrar's Signat	ture	eace un	ve Del	+tiv 1"	-	-10	1 -[
Registra	ır	SEP 0 7 2012	anula B.	gare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Linda D. Tidwell Month 09 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □ F Months Min 141-46-7019 Days (Month, Day, 1953 59 New Jersey **Director** Yrs Usual Res sidence of Decedent 28a-f shor at 10b. County the Maryland 10c. City. Town or Location Director notified MD Harford Bel Air 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a 607 N. Tollgate Road 21014 **USA** items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 14. Race - American Indian, 6:15 a.m. traumatic event, the Medical Examiner Armed Forces? 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give "natural", 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education cify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Worker Healthcare 2012 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charlie Tidwell Marjorie Barnes SEPTEMBER 6, and list ma 19a. Informant's Name/Relationship (Type, Print) Chawn Tidwell / Son item 27 307 Regency Court, Middletown, NY 10940 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/8/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Derota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): the burialthe attending physician Physician/Medical P.O. Box 68760 as F FEMALE: use a yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) LINDA TIDWELL Ectopic pregnancy in the past 12 Month 2 X No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, is certificate has been sig director, page 2 should b 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No ျ After this 1 Inpatient 2 ER/Outpatient 3 DQA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes Accident Investigation 2 No within 24 hours after death

To the Funeral Director: / 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

6:15

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

TIMONIUM, MD 21093

Year

Black

1X Yes 2 No

 $A^{M}$ 

Registrar

State

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**CRNP** 

MORGAN,

TRACIE L.

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

•		_	Plea	se Type or Pr State of N							_		_	jible.		
	-	For State Registrar			, , , , , , , , , , , , , , , , , , , ,		ertifica				-	Reg. No	20	712	2864	
Physicia: Medic		1. Decedent's Name	e (First, Middle,	Last) Karen Lyı	nn Tilgl	hman					2. Date of De Month 08	ath Da	y	Ž612	3. Time of Death	•
Examin		4a. Facility Name (if a 2874 Aspe		give street and number) ad			4b. Cit	y, Town, or	Location o			40	. County	of Death Balt	imore	
Funeral Director		5. Social Security Nu 220-52-3		6. Sex 1 □ M 2 X F 7. A	ige (In yrs. 1	last birthday, Yrs.	) If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da		9	9. Birtl Cou	nplace (State or Foreign Maryland	
at w	١	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or L	ocation								10d. Inside City Limits	_
Marylar 8a-f sl tiffied	rectc	MD	В	altimore		,			Parkv	ille					1 X Yes 2 □ No	)
h the a	Funeral Director	10e. Street and Num			<del></del>		10f. Z	ip Code			10g. Citizen of					
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s aner des ral", or ite Examiner	ò	1 Never Marria 3 Widowed		Armed Forces	2	3.	If Yes, sp	ecify Cubar	n, Mexican Specify:	, Puerto	Rican, etc.)			ck, White		
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permit. Page 1 and 2 should be lined within 72 hours after death with the Maryland permit. Page 1 and 2 should be lined within 72 hours after the marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1  Burial 24 4  Donation	Cremation	3 ☐ Removal from Stat	te C	Place of Disponentery, cre Chesape	ematory or	other place			Date /2012	20c. L			Fown, State	
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direct	To Be	examiner? 1 X Yes 2	□No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpati	ent 3 🗌 I	Othe	ar.	· · · · · · · · · · · · · · · · · · ·	me 5 Resid	dence 6	6 ☐ Oth	er (Specii	fy)	
	Certificate:	27. Manner of Death  1 X Natural  2 Accident	5 Pending	ation	jury Pay, Year)	28b. Time Injury	of M	28c. Injury work' 1 🗆			28d. Describe h	now injur	y occurr	ed		
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in 24 hou he Funer	Medical	(Check 2		Physician: To the best of caming of the basis of Nurse Tractioner: To the	examinatio	n and/or inve	estigation, i	n my opinio	n, death oc	curred at	the time, date a	and place	e, and due	e to the ca	ause(s) and manner state	d.
Veith Corr		29b. Signature and t	title of cartifler	116			29	c. License				29d. Da	-		Day, Year)	
\ ;		30. Name and addre	ess of person w	who completed cause of	death (Item	n 23a) (Tivne	Print\		D-149	957			8	3.31.20	012	
4		Stephen R Si	with MD	8709 Harford	Rd Ra	ltimore	MD 2	1234								
Stat Registra	e	31. Date filed (Month	SFP 07	2012 32 Regist	trar's Signa	B. A	arks									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Margaret Ε. Trott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carrol1 Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In yrs. last birthday) (Month, Day, Year) Country)
MD Days Hours 217-20-6923 86 1 □ M 2 🔏 F Director July 16 1926 item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State should be filed within 72 hours after death with the Maryland Director MD Carroll Eldersburg 1 Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 6203 Walnut Avenue Funeral 21784 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🌠 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2 M Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ George Deuchler Margaret Mulroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6203 Walnut Ave., Eldersburg, MD 21784 Mr. Henry Trott (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 🛣 Burial 2 🗌 Cremation 3 🗎 Removal from State 9-7-12 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Day Jaight Serbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate NON-STEESVATION MYOCARDIAL INFARETIC Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any leading to in necliate cause. Enter Underlying Cause (Disease or injury Disk to for as a consequence of ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month Month Year Pregnant at time of death Yes 2 No q 🗌 Unknown g Unknown ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A: 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29c. License number D 30263 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO MD 200 METWORIAL AVE WESTMUNSTER MO 2115-31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP U 7 2012 Registrar

	1	For State Registrar	ne (First, Middle	Last)		Cei	rtificate c	of Death		2. Date of	Reg. N	<sub>10.</sub> 20	12	286
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amend State of Marylane Department of Health and Mental Hygiene

achel Lee Ved	chic	1- For State Cortif	ment of Health and Mental Hygiene 20   2 2864
Physici Nedical Exam		Decedent's Name (First, Middle,Last)	Reg. No.  2. Date of Death Month Day September 4, 2012  Reg. No.  3. Time of Death 1608 hrs
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital	4b. City, Town, or Location of Death  Baltimore  4c. County of Death  N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or 1980)   1980   198
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Baltimore  10e. Street and Number  8102 Dogwood Road  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  12 Years  17. Father's Name (First, Middle, Last)  David M. Vecchioni  19a. Informant's Name/Relationship (Type, Print) Roff Debora J. Buberyk (Mother)  20a. Method of Disposition  20a. Method of Disposition  1 Roff Debora J. Subject of State Completed State Completed  20b. Place Completed  20c. Place Completed  20b. Place Completed  20c. Place	## or Location  Edgemere  10f. Zip Code 21219  10g. Citizen of What Country?  United States  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No specify:  a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Clerk  18. Mother's Name (First, Middle, Maiden Surname)  Debora J. Bubczyk  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8102 Dogwood Road Edgemere, Maryland 21219  e of Disposition (Name of cemetery, latery or other place)  top Service Corp. 9/7/2012  Towson, Maryland  22, Name and Address of Facility Duda—Ruck Funeral Home of Dundalk, Inc.
Physician Modical xaminer	Examiner	failure. Let only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Cipsease or injury that initiated	not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  ne) Intoxication  Approximate Interval Between Onset and Death
i, P.O. Box 68760, irs that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown 9 Unknown	I—f , per me , g931 9—20—12 sm 9—28—12 sm  2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (Specify)  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box 68760,  To the Huspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Certification: To Be Completed	1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 SC Could not be determined (Specify) Parki  29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, do	24a. Was an autopsy findings available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E. September 5, 2012
Sta Regist	ate rar	31 Date filed (Month, Day Year) 32 Registrar's Signatures	900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar 28649 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Albert Vanik, Jr. 2012 14:45 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford County Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) May 7, 1933 . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 213-30-2345 Director 1 XM 2 🗆 F 79 Maryland Usual Residence of Dece 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ems 23a or 28a-f st. r must be notified a Maryland Harford County Bel Air 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 21015 2504 Bounty Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces: 14 Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify: 3 - Widowed 4 - Divorced Year or Dates traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore County Police Dept Police Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o မ Anna L. Spealman Edward Albert Vanik, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 2504 Bounty Court, Bel Air, Maryland 21015 Lorraine R. G. Vanik (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Sept. 6, 2012 | Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee tvans Funeral Chaper & Cremation Services - Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS Physician/ WEKKI Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical E FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🛂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perforn within 24 hours af er death.

To the Funeral Director: / Iter this certificate Yes 2 N 1 🗌 Yes 🔑 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} Hospital: Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural or Attending 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 3 🗌 Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature DUU56296 -5-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Jason Bimbaum, M.

September

00

Albert

Edward

Vanik

Bel Air, Maryland 21014

520 Upper Chesapeake Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28650 Certificate of Death 1. Decedent's Name (First, Middle, Last)

Joseph C. Villa 2. Date of Death 3. Time of Death Physician/ September of 20°1°2 6:00a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 304 Chelsea Court Sykesville Carroll 5. Social Security Number 8. Date of Birth (Month, Day, Ye March 26 Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Min. Months 1 XM 2 □ F 192<u>3</u> 89 Hours Country) 217-14-0496 **Director** MD Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Halethorpe 1 🗌 Yes 2 🗌 No 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 5907 Oakland Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. or i Yes 2 No Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Hygiene. other than "natural", Specify: white 3 ♥ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) engineering engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pietro Villa Mariano Provini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Chelsea Court, Sykesville, MD 21784 Mrs. Toni Picker (daughter) 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date Cemetery, crematory or other place)
All County Cremation 9-7-12 20c. Location - City or Town, State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner HTAPOM CHAS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 L Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available has 3 2 prior to completion of cause of death? autopsv 2 No 1 TYes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) the Hospital or Attending Pithin 24 hours after death.
I the Funeral Director: After the properties of the funeral propert 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Certificate of Death 1 - For State Registrar 28651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 08/31 72012 Weinreich, Sr. James A. 8:00 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminister If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Country Director 92 218-03-4082 1 🗶 M 2 🗆 F 11/26/1919 MD Usual Residence of Decedent 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Carroll 1 Tes 2 X No MD Westminister ō 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral USA 21157 505 High Acre Dr., Apt. T31 or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner Armed Forces?
1 

X Yes 2 □ No
If Yes, Give þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 + Yes 2XXNo Specify r than "natural", the Medical Exa White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Piston Ring Mfg. 8 Machinist and Mental Hygie is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file i Mental ပ Verda Stevens Charles Weinreich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a Evelyn Weinreich / Wife 505 High Acre Dr., Apt. T31, Westminister, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once, 1 Burial 2 Cremation 3 Removal from State 09/05/2012 Woodlawn, MD Woodlawn Cemetery ☐ Donation 5 ☐ Other (Specify) 21. Signati 22. Name and Address of Facility of Funeral Service Licensee <sup>2. Name and Address of Facility</sup> Hubbard Funeral Home, I 4107 Wilkens Ave., Baltimore, MD 21229 Daniel Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and -trar that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ L g ☐ Unknown the Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe this certificate Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury odcurred 4 within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 041 0 Date filed ( Registrar's Signature State Registrar

8-23-12 WRIGHT, JACQUELINE Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12:32 pm State of Maryland / Department of Health and Mental Hygiene 28652 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WRIGHT STA 08/2 TACQUELINE 12:32PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Thomas Moore HYattsville 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Min. Hours 2 M9 11 0 1 1946 578580529 **Director** Usual Residence of Decedent shov State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WASHINGTON 28a-f 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2Nd. STrEET ISA 20002 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLack 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) nstrument Examiner Be 17\_Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o P permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wright Sister JEFFERSON St. ME., Iammy 20b. Place of Disposition (Name of cemetery, crematory or other place). 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Suitland, MD 11112 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Service Licen HOSH Name and Address of Facilit , Henry Funeral Nome Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the burial-transi or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed obstructive Pulminam 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Di Hou autopsy 2 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural iniury 5 Pending 2 Accider
3 Suicide Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital of 24 hours a within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 006368 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. HAIT ASAIR ROOD, HVATTSVIlle MD Kurup 4922 L 20782 31. Date filed (Month, Day, Yea SEP 0 7 2012 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 4:15 AM JOSE 2012 Medical street and number) 4c. County of Death **Examiner** Balto City 1more Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)unk **Funeral** Director 1 2 M 2 □ F death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore 1X Yes 2 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21217 IISA 717 Druid Park Lake Dr; Apt 1309 11. Marital Status . Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. or i þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) home improvement painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Dukeland St; Baltimore, MD 21216 Octavia Wilson - granddaughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 to Other (Specify) in State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Rart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician HTheroscleroti Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (of as a consequence of): burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: ase 23b. Was decedent pregnant 23d. Date of delivery eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy performed death? Yes 2 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print)

Registrar

		1 _ State	s <b>e Type or Pri</b> State of M	aryland		artment o tificate o			/lental Hy		010	00001
Physi Me	cian/ dical	Registrar  1. Decedent's Name (First, Middle,  John Charle			061	incate o	Dear		2. Date of De Month Septer	nber 3,	2012 20112	3. Time of Death 8:25 P M
	niner	4a. Facility Name (if not institution, Stella Maris	Hospice			4b. City, Town	nium_			Bal	nty of Death timore	
Funer Direct	_	218-40-1847 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. las:	Yrs.	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da July	rth ay, Year) 23 <u>,</u> 194	0 Mary	land
ne Maryland or 28a-f sho notified at	Funeral Director	10a. State 10b. County  Maryland Harfo  10e. Street and Number	rd		Town or Loc		e		***	10a. Citizen	of What Coun	0d. Inside City Limits  1 ☐ Yes 2 🙀 No  trv?
filed within 72 hours after death with the Maryland fall Hygiene. at Hygiene. of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	2831 Pleasant	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	210 Vas Decedent of Yes, specify C	047 of Hispanic	Origin? (Spe	ecify Yes or No- Rican, etc.)	USA 14. F	Race - Americ	an Indian,
2 hours after "natural", or	Completed by	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give Year or Dates.	No	16a. Deced	Yes 2X	cupation			Spec	office -	ite
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1 and 2 should be filed of Health and Mental Hy fitem 27 is marked out rother traumatic even	10	Robert Joseph  19a. Informant's Name/Relationsh	Wagner		19b. Mailin	ig Address (Str	He	len (u	nk) Ale	exander ex, City or Town		Code)
f Heal f Heal item		Barbara A. Wagn  20a. Method of Disposition  1 ABurial 2 Cremation			ce of Dispo	Pleasar sition (Name of natory or other		1	d, Fal		Maryla on - City or To	nd 21047 wn, State
permit. Page 1 and Department of Hee Important: If item any injury or othe	ouce.	4 Donation 5 Other (S)	pecify)		22	Cath.  Name and Ad	dress of F	acility MC		Hydes, Funeral nadon.	Home,	
Physicia	nf.	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause only one cause on each lin	e.	Do not ente	er the mode of o		_				Approximate Interval Between Onset and Death
Medical Medica	Examiner	Sequentially list conditions, if any, leading to immediate the first of the cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	a conseque	nce of):							
requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal	death 3	Ectopic pregr Other <i>(specif</i> )					Date of delive	ery Day Year
equires that the sen signed by ould be detay	þ	Part II. Other significant conditio	ns contributing to death I	out not resul	ting in the u	nderlying caus	e given in l	Part I.	1 🗆	Yes 2□N	o 3 🗆 Prot	ne cause of death?  Dably 4/1 Unknown
ysician: The law requires is certificate has been sig director, page 2 should t	Be Completed	25. Was case referred to medical				26	S. Place of	Death (Chec	perl 1 🗆 Yes	s an 24 opsy formed? 2 <b>X</b> No	b. Were autop prior to co death? 1 Yes	osy findings available mpletion of cause of
ig Phys ter this neral di	Certificate: To B	examiner?  1 Yes 2 X No  27. Manner of Death  1 X Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determine	28a. Date of inj (Month, Date of Inj ation and 28e. Place of Inj	ary 2 y, Year)	8b. Time of injury	28c. I	njury at vork? .   Yes		28d. Describe 28f. Location	how injury occ	urred	HOSPICE  Route Number,
To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: Af completely filled in by the fu	Medical C	(Check 2 Medical E	Physician: To the best of caminer: On the basis of Nurse Practitioner: To the	f my knowled	and/or invest	tigation, in my o	pinion, dea	th occurred a	nd due to the o	cause(s) and m	due to the car	use(s) and manner stated
To the withir To the comp	2	29b. Signature and title of certifier	seam	2		29c. Lic	ense numb				med (Month, 1 4/201	
-[		30. Name and Address of person v	who completed cause of			rint) LEY RD	m-r		1, MD 2	1000	•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RI6HT 8:354 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death nty of Death (5 rive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday Min 784055 Director 1 🗆 M 2 📈 F 3/1930 end Martel Hygiene. Ie marked other then "neturel", or Iteme 23e or 28e-f show eumetic event, the Medical Examiner must be notified at permit. Pege 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hyglens. Importent: If item 27 ie marked other then "neture." ery injury or other treumetic average. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 □ No WalderF 10e. Street and Number 10a. Citizen of What Country? Funeral 20601 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working if DO NOT use retired) (Specify only highest grade completed) MARRIUTT condary (0-12) College (1-4 or 5+) ORPOVATION Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) SAlmons 19a. Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code) , waldoer SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 100 Sun ture of Funeral Service Licen ome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final oncer Onset and Death Priysician/ disease or condition resulting in death) once Medical Due to (or as a consequence of) Examiner id ney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 🖼 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 ☐ Yes 2 W No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Vithin 2 only one) 29b. Signature and title of certifier 46285 Our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FT. Washington - Washington Rd. #200

DHMH 17 Rev 06-2011

State Registrar 32. Registra Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20c, per fh, 931 9-7-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUG U Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TOW SON MEDICA BALTIMOR Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Days Hours Min. (Month, Day, Vear 215.28-4030 8 **Director** 1 M 2 □ F TIMOREIN 10a, State 10b. County 10c. City, Town or Location death with the Maryland er than "natural", or items 23a or 28a-f sho the Me lical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 09 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Anned Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Completed Specify: 3 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. chols -Be Maryland permit Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Maiden Sug မ Debste 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Forest Hill, MD. Date 5 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL 22. Name and Address of Facility 16924 York Signature of Funeral Service Licensee Rd. Monkton MOZIIII from SERVICES-Monkton EvansFuveralCha sele (roma or omplic 23a. Part 1. Enter the diseas shock, or heart cilure. Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ REBELLAR HEMORRHAGE ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last eral Director: Affer this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rtend 29,5015 Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28657 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 02, William T. Wedemeyer 2012 2:19 A M September 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Baltimore Nottingham 4108 Westmeath Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday 1**X**XM 2 □ F Hours 78 218-28-0521 Baltimore, Maryland February 12,1934 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d Inside City Limits Nottingham Baltimore Maryland 1 Yes 2 XNo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21236 4108 Westmeath Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 XXYes 2 No
If Yes, Give
Year or Dates. Black White etc 1 Never Married 2XXMarried 1 Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police Officer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Naomi Gilbert Norman A. Wedemeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Wedemeyer (Spouse) 4108 Westmeath Road Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Dulaney Valley Memorial Cambens 1 Burial 2 ☐ Cremation 3 ☐ Removal from State September 06, Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Name and Address of Facility Evans Funeral Chapel & Cremetion Services—Parkville 8800 Harford Road Parkville, Maryland 21234 Signature of Funeral Service Licens Jalli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearthsiure. List only one cause on each line. Approximate Interval Between 2 month Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical **Examiner** 

> and burial-trar

attending physician for use as the burial

detached for

page 2 should be

the

signed by

Director: After this certificate has

the funeral director.

upleted filled in by

To the Hospital within 24 hours a To the Funeral D Hospital

I or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

Completed by

Be

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Certificate:

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Physician/

Medical

Examiner

**Funeral** 

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28a-f show

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3altimore, Maryland 21215-0036

ral", or items 23a or 28a-f shore Examiner must be notified at

"natural"

n and Mental Hygiene.

: Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked or

Medical

the

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other

ò Department of Important: If any injury or once.

> Sequentially list conditions, if any, leading to immediate cause. Enter chosenthing Cause (Disease or iinjury that initiated events resulting in death) Last

24a. Was an autopsy performed ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 2 🗖 No

25. Was case referred to medical examiner? 27. Manner eath

Natural

Accident
Suicide

28a. Date of injury (Month, Day, Year) 5 Pending Investigation

Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? 1 🗌 Yes

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SQUARE DRIVE BALTIMORE, MOZIZZ

29a. Certifier (Check

🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Suman

Could not be

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

Registrar

RANKLIN 910 SUMAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Ma	iryland /	Department of H  Certificate of D		lental Hyg R	eg. No. 2012	28658
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	Physicia Medic		Anne Seifert Weaver				Septembe		04:17 A <sup>M</sup>
į	🐧 Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County of Death	1 -
	Funeral		Hart Heritage  5. Social Security Number   6. Sex   7. Age	(In yrs. last bir	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Harford 9. Birt	hplace (State or Foreign
	Director		168–18–6197 1 ☐ M 2X F Usual Residence of Decedent	90	Yrs. Months Days	Hours Min.	Dec. 10	, 1921 Penr	hplace (State or Foreign Intry) Faston Isylvania
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	for	10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
	Mary 28a-f notifie	Director	Maryland Harford	Fore	est Hill				1 ☐ Yes 2 X No
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	eath w	Funeral	1915 Bear Creek Dr.  11. Marital Status 12. Was Decedent E	ver in U.S.	21050 13. Was Decedent of His			14. Race - Amer	'
36	after de ", or if	by	1 ☐ Never Married 2 ☐ Married  Armed Forces?  1 ☑ Yes 2 ☐ If Yes, Give		If Yes, specify Cubar  1 ☐ Yes 2 🔀 No		rican, etc.)	Black, White	
8	atural	etec	3 ▼ Widowed 4 □ Divorced Year or Dates.	1945 1945	a. Decedent's Usual Occupa	ation		16b. Kind of Business	
Baltimore, Maryland 21215-0036	in 72 h e. nan "n	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5-	+)	(Give kind of work done do life. DO NOT use retired)	uring most of work	ing		,
121	d with tygien ther th	Be C	47. Fahhaula Nama (Fireh Middle Lock)	CI	laims Adjuster —			Government	
and	be file antal H ked of c even	70 B	17. Father's Name (First, Middle, Last)  Elbert F. Seifert			18. Mother's Nam		naiden Surname)	
ary	nd Me		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Street a			City or Town, State, Zip	Code)
Š	id 2 sh salth a n 27 is er trai		Mrs. Svlvia Harris (Daughter)	1	1915 Bear Creek I	Drive, Fore	est Hill, I	Maryland 2105	0
ore	pe 1 ar t of He If item or oth		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ Removal from State		of Disposition (Name of ery, crematory or other place		nber 07,	20c. Location - City or	Town, State
Hi m	iit. Pag irtmen irtant: njury		4 Donation 5 Other (Specify)		Memorial Garde	ns : 2	2012	Bel Air, Mary	
Ba	permit Depar Impor any ir		21. Signature AlFuneral Service Licenses Jeffrey R.	'lesterma (M01543)	Evans Funeral 3 Newport Driv	Chapel & (	remation :	Services - Be	l Air
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do	not enter the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	hydici n/		Immediate Cause (Final disease or condition routhing in death)	ID ST.	AGR Dem	ent A			Onset and Death
and the same	Medical Examiner		Due to (or as a	consequence	e of):				
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_	ate be executed physician and the burial-transit	alE	resulting in death) Last Due to (or as a	consequence	3 OI).				
	icate t physis the l	fedical	d				<del>-</del>		
Box 687	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 ☐ Live Birth	of pregnancy 2  Fetal dea	ath 3 🗆 Ectopic pregnanc	у		23d. Date of del	
Bo	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?  1   Yes   2   No   4   Pregnant at   9   Unknown					Month	Day Year
P.O.	hat the	by Ph	Part II. Other significant conditions contributing to death be	ut not resulting	g in the underlying cause giv	en in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
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Sorc	aw req as bee 2 shor	Completed					24a. Was a	by prior to	topsy findings available completion of cause of
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ital	sician certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		_ Othe	ace of Death (Chec		- Hay 10	Assisted 6
of V	g Physer this eral di	은: <u>1</u>	27. Manner of Death 28a. Date of injur	y 28b.	Outpatient 3 DOA  Time of 28c. Injury work	at		ence 6 Other (Spec ow injury occurred	ITY) CATAL
ono	ending sath. or: Afte he fun	ficat	2 Accident Investigation	, rear)		? Yes 2 □ No			
Division of Vital Records,	To the Hospital or Attending Physician: The ka within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc		farm, street, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
Ω	hours hours neral l	Medical	29a. Certifier 1 Certifying Physician: To the best of	my knowledge	e, death occured at the time,	date and place, a	nd due to the cau	se(s) and manner as sta	ated.
	the Ho nin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of examiner) 3 Certifying Nurse Practioner: To the	kamination and best of my kno	Vor investigation, in my opinio wledge, death occurred at the	n, death occurred a e time, date and pla	t the time, date an	d place, and due to the cause(s) and manner as	stated.
	5 Table 10 T		29b. Signature and title of certifier		29c. License	number	3 2	29d. Date signed (Month	n, Day, Year)
	idt		30. Name and address of person who completed cause of do	eath (Item 23a)	) (Type, Print)	2100	/	sept chin	7 4, 2010
	IV		ALMAN SPARLY	615	W. MACPI	1 B. / Be	21 Ain	ND 21	014
	Sta Registr		29b. Signature and title of certifier  30. Name and address of person who completed cause of de Company Start Star	ar's Signature	park		<u>.</u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical cility Name (if not institution) give street and number) Location of Death Examiner 4c. County of Death Date of Birth (Month, Day, Year) Numberunk If Under 24 Hrs Birthplace (State or Foreign Country) unk **Funeral** 7. Age (In yrs. last birthday Months Hours Director 67 1 ፟ M 2 □ F Yrs March 20, 194 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hyglene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Director 1 A Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21231 603 S. Ann St. 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Woods 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖺 Other (Specify) in state Ronald 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burlel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year signed by the at Id be detached fo Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, s certificate has been sidirector, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗵 No မှ 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 000 RES 2012

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

		Please	e Type or Print in E			-	_	
		ForState	State of Maryland	d / Department of I		Mental Hygie	ne .	2 20000
		Registrar		Certificate of l	Death	Reg	. No. 201	2 28660
Physicia Medic		1. Degdent's Name (First, Middle, La Gray Phen	/\ 1	ona		2. Date of Death Month	2 4, 2592	3. Time of Death 2 6:30 P M
Examir		4a Sacility Name (I not institution, gives	restreet and number)	J 4b. City, Town, o	r Location of Death		4c. County of Peat	nore
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birl	thplace (State or Foreign untry)
Director		Usual Residence of Decedent	1 □ M 2 🕪 F   88	Yrs.		11/8/19	123	NC
Merylend 28e-f show	[당	10a. State 10b. County	10c. City,	, Town or Location		•		10d. Inside City Limits  1 Yes 2 \( \square\) No
e Me r 28e	훒	10e, Street and Namber		10f. Zip Code		Lie	Control of the contro	
Baltimore, Maryland 21215-0036  permit. Pege 1 end 2 should be filled within 72 hours efter death with the Menylend Depertment of Heelth end Mentiel Hyglene. Importent: If Item 27 is marked other than "neture!", or Items 23e or 28e-f sho ship injury or other treumetic event, the Medical Examinar must be notified at once.	Funeral Director	1636 Ruxton	Avenue	218	216	100	. Citizen of What Co	ountry ?
r iten		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp 3n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
21215-0036 within 72 hours efter glene. er than "neturel", or er than "neturel", or it it medical Exam	ed by	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No	Specify:		Specify: B	ack
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re, Ma 1 end 2 sh of Heelth en item 27 is other treu		Wilbert C. Arm	strong, Jr	10368 Hunt	er Creek		noe. Ix	77304
altimore, rmit. Pege 1 enc pertment of He portent: if item y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [		ace of Disposition (Name of metery, crematory or other plan	ce)	Date 20	c. Location - City or	^ ~
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Balti permit. Depertri imports sny inju		21. Signature of Funanci Service Lice	Lileno	2 1000 g 44°	ssor Factor Re	ne Funer	w Serv	ices
	Н	23a. Part 1. Enter the disease, or cor shock, or hear failure. List only	nplications that caused the death	. Do not enter the mode of dyir	ng, such as cardiac		2100	Approximate
- Pnysician/	1	Immediate Cause (Final disease or condition	one cause on each line.	hire-		\		Interval Between Onset and Death
Medical	Ш	resulting in death)	a. Due to (or as a conseque	ence of):		7	-	cays
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387 ortifice ling p	ığ	IF FEMALE;	225 Kura subserve of sussess		1 1/6	14.1.		
Box 6876( deeth certificete the ettending physical for use es the	盲	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome of pregnan  1 ☐ Live Birth 2 ☐ Fetal  4 ☐ Pregnant at time of de	death 3 Ectopic pregnary	64/500	1.5	23d. Date of de Month	livery Day Year
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ords, P.O. Box 6876( requires that the deeth certificate been signed by the ettending phys should be deteched for use es the	ted					1 ☐ Yes	2 <b>X</b> ONo 3 □ P	robably 4 🗆 Unknown
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of V a Phy er this	  ë	27. Manner of Death	28a. Date of injury	28b. Time of 28c. Injur	4 ∐ Nursing H	ome 5 Residenc		ity) 140 Sp1 Co
Division of Vital Records, P.O. Box 6876( tal or Attending Physicien: The lew requires that the deeth certificate rs efter deeth. In Director: Affer this certificate has been signed by the ettending phys ed in by the funerel director, pege 2 should be deteched for use es the	flcat	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not		injury worl	(? Yes 2 No	Fall		
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Division of Vital Recc no the Hospital or Attending Physicien: The lew within 24 hours effer deeth. To the Funerel Director: After this certificate has completely filled in by the funerel director, page 2	Medical Certificate:	(Check 2 L Medical Exam	niner: On the basis of examination arse Practitioner: To the best of my	and/or investigation, in my opini-	on, death occurred a	at the time, date and p	lace, and due to the	cause(s) and manner stated.
vith To th		29b. Signature and title of certifier		29c. Licens		29d	. Date signed (Monti	h, Day, Year)
<b>9</b> 9		Male	<i>n</i> s	DS	8303		eptember	5 2012
0		30. Name and address of person who	completed cause of death (Item :	23a) (Type, Print) 5101 N . Char	de ST.	Thuspal	MO	
Sta	te_	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	B A A		10103014		
Pegistr		CED 1 0 2	117 1 /2 was 6	Barks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ uanbur Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 5430 Bucknell Road Baltimore Social Security Number 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 242-56-9739 Director 1 □ M 2 🖾 F 04/15/1935 Yrs S.Carolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: If them 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic event, the <u>Medical Examiner</u> must be notified and another. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5430 Bucknell Road 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lerner's New York Salesperson vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Gamble Maggie Samuels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Molissa Wheeler/daughter 5430 Bucknell Rd.Baltimore, Maryland 21206 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/01/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore Maryland 21206 . Signature of Funeral Service Licensee ula 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardionnombotic event Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiovascular Disease aTheroschnotic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has funeral director, page 2: performed? Yes 2 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical a 26. Place of Death (Check only one) Other: Certificate: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director; Af 2 Accident
3 Suicide 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRajapathemo 00057-465 9/6/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 NS RajupakseMD 2835 SMIMN 5203

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

SEP 1 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles-Henri 2012 Bonhomme <u>August</u> 30. Medical 8:26 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Unde 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 1 **X**M 2 □ F 577-60-9491 70 Yrs. May 27, 1942 Haiti show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 ☐ Yes 2X No 10e. Street and Numbe items 23a or ner must be n 10f. Zip Code 10g, Citizen of What Country? Funeral 10002 Lorain Avenue 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Electrical, Computer Elementary/Secondary (0-12) College (1-4 or 5+) and Administrative 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Arthur Bonhomme. Andrea Louis-Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marie-Claude Bonhomme / Spouse 10002 Lorain Avenue Silver Spring. MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 09/08/2012 Silver Spring. MD 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). Exami that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗶 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at after death. Director: After 28d. Describe how injury occurred 1 X Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State 24 hours

P.O. Box 68760 Division of Vital Records, or Attending Physician: The law requires

Maryland 21215-0036

Baltimore,

within 24 hor To the Fune completely fi State

Medical

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel K. Sherk 1500 Forest Glen Road, Silver Spring, MD 31. Date filed (Month, Day, Year)



Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 08-30-2012

20910

29c. License number

**D67355** 

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cert	tificate of D	Death		Reg. No.	2012	28663
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of D		Year	3. Time of Death
jt.	Medic	al	Howard Francis Baker				Septem			6:25 P M
	Examir	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. (	County of Death	
	Funeral		Golden Living Center  5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday)	If Under 1 Year	Westmil		rth		roll place (State or Foreign
	Dîrector		190-12-3420 1x3 M 2 □ F 87	Yrs.	Months Days	Hours N	Ain. (Month, D		924 Peni	nsylvania
	nd now at	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	wn or Loc	ation					10d. Inside City Limits
	arylar aa-fski ified	Director	Maryland Carroll		Union Br	ophi				1 ☐ Yes 2 🔀 No
	or 28 or 28 e noti		10e. Street and Number		10f. Zip Code	ruge		10g. Citi:	zen of What Cou	ntry?
	with s 23a ust b	Funeral	235 Stem Rd.			21791			U.S.A	•
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)	. 1	14. Race - Americ Black, White,	
Maryland 21215-0036	e fled within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		5	Specify: Whi	
15-0	2 hour	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	(Give ki	ent's Usual Occupa ind of work done d	ation luring most of	working	16b. Kir	nd of Business/In	dustry
121	within 7; giene. ler than t, the Me	Com	Elementary/Secondary (0-12) College (1-4 or 5+)		NOT use retired) mill for	eman			feed 1	mill
d 2	filed w al Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)		MITTI TOL		Name (First, Middle	, Maiden S		
/lan	ould be fil nd Mental marked o	인	Roy George Baker			Er	mma Riley			
lan	should and it is ma		19a. Informant's Name/Relationship (Type, Print)	∂b. Mailing	g Address (Street a	and Number or	Rural Route Numb	er, City or 7	Town, State, Zip	Code)
<b>≥</b>	1 and 2 should be the Health and Men item 27 is marked other traumatic				tem Rd.	Unio	on Bridge			
Baltimore,	Page 1 and		1 Burial 2 X Cremation 3 Removal from State cemeter	tery, crema	ition (Name of atory or other place y Cremat		Date /5/2012	1	cation - City or To cesville	
Balti	permit. Page 1 Department of Important: If i any injury or once.		21. Signator of Furgeral Service Licensee	22.	Name and Addres	s of Facility	Hartzler	Funer	al Home	
			23a. Part 1. Enter the disease, or complications that caused the death. Do		O. Box 2		<u>ew Windso</u> diac or respiratory a		) 21776	Approximate
	Ph_sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Δ.	10.11	1	e 1			Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or as a consequence	e of):	tery 5	roen	De			IWEEK
Separation of the second	Examiner	er	Sequentially list conditions, b. A ther osci	Dero	to l'a	rdrove	uscular	De	sease.	20 years
	ed sit	mine	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury	e of):					- 1	
	rificate be executed ing physician and e as the burial-transit	Examin	that initiated events resulting in death) Last  C	e of):						
0	e be e ysiciar e buri	Medical								
8760	tificat ng ph s as th	Mec	IF FEMALE:							
9 x	th cer ttendi or use		23b. Was decedent pregnant in the past 12 months?			у		2	23d. Date of deliv Month	ery Day Year
P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death says a steer death or a form the same and the same and the steer steer and the same and the sam	Completed by Physician	1   Yes 2   No 4   Pregnant at time of death 9   Unknown	5 🗆	Other (specify)			$\perp$	Widitii	Day Ioai
P.O.	that t	by P	Part II. Other significant conditions contributing to death but not resulting	j in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	he cause of death?
ds,	requires been sig should b	ted	Advanced Age				1 □	Yes 2	No 3 ☐ Pro	bably 4 🗆 Unknown
COL	has be	nple					24a. Was	psy		psy findings available impletion of cause of
Re	sician: The certificate irector, pag		25. Was case referred to medical					ormed? 2 No	1 Yes	2 🗆 No
/ita	siciar certifi	o Be	examiner? Hospital:	Dt	_ Othe		Check only one)			
of/	ling Physician: The la n. After this certificate ha funeral director, page	te: To	27. Manner of Death 28a. Date of injury 28b.	. Time of	28c. Injury	at	ng Home 5 Res 28d. Describe			//
on	endin sath. or: Aft the fur	ficat	2 Accident Investigation	injury	M 1 🗆	? Yes 2□No				
Division of Vital Records,	l or Attending after death.  Director: After din by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fi building, etc. (Specify)	farm, stree	et, factory, office		28f. Location ( City or To		Number or Rura	Route Number,
۵	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death or	curred at the time	date and play	ce and due to the	alise(s) an	d manner as stat	ed
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2   Medical Examiner: On the basis of examination and/only one) 3   Certifying Nurse Practitioner: To the best of my known	or investig	gation, in my opinion	n, death occurr	red at the time, date	and place, a	and due to the ca	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier  Language CRN	10	29c. License		,	29d. Date	e signed (Month,	
J			I have at 1 demon .	•	700	9707	<u>′</u> l	04		2012
)			30. Name and address of person who completed cause of death (Item 23a)  ALQUELING PUEL RNCRNP 688  31. Date filed (Month, Day, Year)  33. Registrar's Signature	(Type, Pri	de Rran	Wad	minster	MI	2115	57
	Stat			ba	Kel					
	Registra	ır	SEP 1 0 2012 Cerem B.	CT "						

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			_ State	Maryland / Depa	artment of H			71117	28664
			Registrar  1. Decedent's Name (First, Middle, Last)	001	tilleate of L	Cutti	2. Date of Dea	th	3. Time of Death
	Physicia Medic		Jean Cameron Bergaust	t			August	30°, 2012°	1:15 P M
	Examin		4a. Facility Name (if not institution, give street and numb Manor Care Potomac	per)	4b. City, Town, or Potomac	Location of Death		4c. County of Deat	
	Funeral Director		5. Social Security Number $071-24-2937$ $1 \square M 2 \sqrt{3} F$	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Se <sup>(Manth, D</sup> ay	9. Birt 5 <sup>Year)</sup> 1929 B <b>f</b> 2	hplace (State or Foreign
	d t t	L	Usual Residence of Decedent  10a. State 10b. County	10c. City. Town or Los	action				10d. Inside City Limits
	arylan a-f sh fied a	Director	Virginia Fairfax	McLean	Sation				1  Yes 2 No
	the Ma or 28 e noti	Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	untry?
	is 23a	Funeral	1548 Westmoreland Street		2210	L		U.S.A.	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	Armed Force  1 Never Married 2 Married 1 Yes  1 Yes, Give	ces? 1 2 K No	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
3	nours a atura cal E)	etec	3 to Widowed 4 □ Divorced Year or Date 15. Decedent's Education		lent's Usual Occup	ation	—Т	16b. Kind of Business	
212	in 72 h e. nan "n : <b>Medi</b>	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4	(Give I	kind of work done a O NOT use retired)	uring most of work	king		indoon y
2	d with lygien ther th	Be Co	2	Exe	cutive			Private	
lano	d be file Jental H arked of	To B	17. Father's Name (First, Middle, Last)  John Cameron Somers				ne (First, Middle, I ine Farr	Maiden Surname) e 11	
, Maryland 21215-0036	id 2 shouli salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print)  Jane Bergaust (Daughter)	19b. Mailir 1548	ng Address (Street a Westmore	nd Number or Rur land St.	al Route Number , McLean	, City or Town, State, Zip • VA 22101	o Code)
Baltimore,	age 1 an ent of He nt: If iten y or oth		20a. Method of Disposition 1 ☐ Burial—2 [X] Cremation 3 ☐ Removal from S 4 ☐ ponation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Cremation	natory or other plac	<sup>e)</sup> VA 9−7−	Date 2012	20c. Location - City or Chantilly,	· ·
Balt	permit. Page 13 Department of P Important: If ite any injury or ot		21. Sign/ture of Funeral Service Licer/ee					ice , VA 22310	
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac	aused the death. Do not ente					Approximate Interval Between
enten.	Ph, sician/		Immediate Cause (Final disease or condition	rtic Ste	nosis				Onset and Death
	Medical Examiner			er as a consequence of):					
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	r ав в сопенционов оп;					
	ate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (o	er as a consequence of):					
9	certificate be nding physicii use as the bu	ledic	d						
20x 68/	leath certif e attending d for use a	Physician/Me	in the past 12 months?  1  Ves 2 X No 4 Pregn.		Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
5.0	at the c d by th etache	Phys	g Unknown 9 Unknown  Part II. Other significant conditions contributing to de	-	inderlying cause giv	en in Part I.	23a Did to	bacco use contribute to	the cause of death?
ds, P	quires tha	ted by	Chronic Obstructi			izease	1 🗆 1		robably 4 🗆 Unknown
Division of Vital Records,	he law re te has be age 2 sho	Completed by					24a. Was a autop perfor	sy prior to or rmed? death?	topsy findings available completion of cause of
īg.	cian: 1	Be	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec	k only one)		
<u>&gt;</u>	Physi r this c ral dir	∋: To	1 ☐ Yes 2 ₹ No 1 ☐ II  27. Manner of Death 28a. Date o	npatient 2 ER/Outpatier f injury 28b. Time of	nt 3 🗆 DOA	4 ♣ Nursing H		ence 6 Other (Spec	ify)
E	ath. r. Afte	icat	2 Accident Investigation	n, Day, Year) injury	work	? Yes 2 □ No		<b>,,</b>	
JIVISIO	al or Atte s after de il Directo ed n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	of Injury - At home, farm, strong, etc. (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or Rui n, State)	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medical	29a. Certifier   1 🕱 Certifying Physician: To the be (Check only one)   3 🗌 Certifying Nurse Practioner: To	s of examination and/or invest	tigation, in my opinio	n, death occurred a	at the time, date a	nd place, and due to the	cause(s) and manner stated.
•	Sold with		29b. Signature and title of certifier  Thomas Masterso	nno	29c. License	0534		29d. Date signed (Month	
	17/1		30. Name and address of person who completed cause Thomas Masterson M		Print) HierAve	#205	M LLeo		
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32. Ke	gistrar's Signature					*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gilbert F. Barnes Sr. 9:19P 9-6-201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-38-0815 73 **Director** 1 XM 2 🗀 F 3-2-1939 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director items 23a or 28a-f s ler must be notified MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1315 Tannery Hill Rd. 21157 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other tha the Master Mechanic Bowling 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked 2 Joshua L. Barnes Eva Maud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Rose Barnes-wife 1315 Tannery Hill Rd., Westminster, MD 21157 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Providence Cem. 9/10/2012| Gamber, MD of Funeral Service Lice 22. Name and Address of Facility Fletcher Funeral & Cremation 254 E. Main St., Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Year 5 Other (specify) Dav Pregnant at time of death detached Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 1 Yes 2 No 3 Probably 1 Unknown Completed rere autopsy findings available prior to completion of cause of death? 24b. Were autopsy findi 24a. Was an has page perform 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how inju-1 Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number Dranna

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

amend #16hate or Maryland / Bepartment of health and Mental Hygiene 28666 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Maurice Costello 30 2012 4:54 PM August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9413 Mellenbrook Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Director 226-28-4246 1 X M 2 □ F Usual Residence of Decedent 87 8/19/1925 Virginia 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9413 Mellenbrook 21045 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 1 ☑ Yes 2 ☐ No 1955— If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced 1960 Year or Dates **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Psychiatry** Physician Phychia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Casino Corbin Evelvn Linscom permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ln. Silver Spring MD 2090<sub>1</sub> Corbin / Daughter 1134 Classical Angela Co 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State -2012 Honover, MD Howell Funeral Home -02-2012 4 Donation 5 Other (Specify) Ardent Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 10220 Guilford Rd. Jessup. MD, 207 94 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ only one) Çé flying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifie D51860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FISIK JON 15 HAN 10700 #200 40 COLUMBIA MO CHARTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 0 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 1124 2012 Medical 4b. City Town, or Location of Death
Ballimer 2 Eacility Name (if not institution, give street and number 4c. County of Death **Examiner** Med ca ent 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** (Month, Day, Year) 87 **Director** 216-18-3130 1 🕅 M 2 🗆 F 08/27/1925 Maryland Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Maryland Baltimore Monkton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17323 Big Falls Road 21111 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Self Employed should be filed with and Mental Hygien 7 is marked other th 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Campbell Anita Jackson or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 17323 Big Falls Rd.Monton, Maryland 21111 Evelyn Campbell/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 09/1<sup>7</sup><sup>t</sup>/12 cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Vet.CemeteryOwings Mills MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Chatman-Harris Funeral Hom 5240 Reisterstown Rd.Baltimore MD.21215 feris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each lip Immediate Cause (Final Embolus Onset and Death monar Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burialinding physician ause as the burial Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day 5 Other (specify) Month Year Pregnant at time of death signed by the a a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Conges tive Hear Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an Was an autopsy performed has prior to completion of cause of death?

1 Yes 2 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅌ ER/Outpatient 3 DOA nours after death.

neral Director; After this y filled in by the funeral di this 1 Mpatient 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ▶ Natural iniury 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

Sunice 31. Date filed (Month, Day, Year)

SEP

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S. Sidhu

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Stree

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sentew Physician/ 11CL VO 10:45AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Country) Director 212-48-8656 1 🛛 M 2 🗆 F Nov. 23, 1945 66 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No WV Morgan Great Cacapon b 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 1049 Johnnycake Rd. 25422 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o þ 1 Never Married 2 Married 2 🔀 No 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 deputy sheriff county government other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ M. Kathleen Martin Claude E. Curfman Sr. of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other tra Phyllis B. Curfman/ wife P.O. Box 128 Great Cacapon, WV 25422 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Paul's Luth. Cem. 9/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Uniontown, MD Signature of Funeral Service 22. Name and Address of Facility Hartzler Funeral Home, P.A. any athan ar Union Bridge, MD 21791 E. Broadway Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Brain seconda disease or condition resulting in death) INIMU Medical **Examiner** Cardiac if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of YOCO di that the death certificate be executed burial-trar and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months Month Pregnant at time of death Dav Year 2 TNO Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, Liselesse 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: |<u>|</u>2 1 Inpatient 2 L 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation M 1 Yes 2 No Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

(Check

only one)

ren (

31. Date filed (MS

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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MERITUS

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug 29<sup>ay</sup> Cathryn Velte Curry 2012 9:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll 2150 Richardson Road Westminster Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 219-05-7232 **Director** 1 🗆 M 2 🕽 F 92 MD 9/4/1919 Usual Residence of Decedent or 28a-f show with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Westminster 1 Yes 2 No MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2150 Richardson Road 21158 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P William Kerwin Eleanore Waldek

Ph\_sician/ Medical

**Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

Division of Vital Records, P.O. Box 68760

	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural R	Route Number, City or Town, State, Zip Code)
	Charles Velte-son	2150 Richardson Rd.,	
	20a. Method of Disposition  1 ☐ Burial 2 N Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)  South Carroll Crem 9/5/	
	21. Sig. ateral Service Licensee	22. Name and Address of Facility leto 254 E. Main St., V	cher Funeral & Cremation Westminster,MD 21157
	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as	Α	Interval Between
Be Completed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of):	
hysician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant 9 Unknown	2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
ted by P	Part II. Other significant conditions contributing to death to Demonth a	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Comple			24a. Was an autopsy performed?  1  Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	nly one)
2	1 Yes 2 Le No 1 Inpati		Residence 6 Other (Specify)
ficate	27. Manner of Death  1 PNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		d. Describe how injury occurred -
Medical Certificate:	4 Homicide determined 28e. Place of Injury	ıry - At home, farm, street, factory, office 28f (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	Check 2   Medical Examiner: On the basis of examiner: On the basis of examiner:	my knowledge, death occurred at the time, date and place, and c xamination and/or investigation, in my opinion, death occurred at the e best of my knowledge, death occurred at the time, date and place,	time date and place and due to the cause(s) and manner stated
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Justille of Stombour	& FNP-PRICEND R1722	82 Aug 30,2012
	30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print)	

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

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To the Funeral Director. After this certificate has been signed by the attending physician and

		For State Registrar	State of Maryla	and / Depa		Health and	Mental Hyg	jiene	012	2867
Physicia Medi		1. Decedent's Name (First, Middle, Last	CAPLK	) M			2. Date of Dea Month		Year	3. Time of Death
Examir		4a. Facility Name (if not institution, give s SUDBROOK MANOR	street and number)			or Location of Death	1	4c. Cou	nty of Death  BALTIM	ORE
Funeral Director	r.	5. Social Security Number 6. Se 526-62-5222 1 1 [  Usual Residence of Decedent 10a, State 10b, County	XM 2 □ F 69	Yrs.  City, Town or Lo	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 04/21/	Year)	Country	MD  Inside City Limits
th the Marylau 3a or 28a-f sl	Funeral Director	MD BALTI  10e. Street and Number	MORE		IMORE 10f. Zip Code			10g. Citizen	of What Countr	1 🗆 Yes 2 🛣 No
Tey, INTAILY INTAILS INTOINED TO SHE INTO THE MARY INTO THE MARKET HE MARKET HE MARKET INTO THE MARKET HE MARKET INTO THE MARKET HE MARKET THE	þ	600 SUDBROOK ROA  11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	.D  12. Was Decedent Ever in Armed Forces? 1		Was Decedent of I f Yes, specify Cub	21208 Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- po Rican, etc.)		USA Race - American Black, White, et	
d within 72 hou lygiene. then than "natu	Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give life. D	dent's Usual Occu kind of work done O NOT use retired NUAL WRI	during most of won ) TER		U.S.	f Business/Indu	•
should be filed and Mental Hy is marked oth	To B	17. Father's Name (First, Middle, Last)  ISRAEL  19a. Informant's Name/Relationship (Ty)	CAPLAN pe, Print)		ng Address (Street	18. Mother's Nan  ELEANC  and Number or Rui			НО	LLINS
• . O		HENNIE CAPLAN/SI  20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify)	Removal from State	b. Place of Dispo cemetery, cren	esition (Name of natory or other pla		Date	20c. Locatio	21209 on - City or Tow	
permit, Page 1 Department of Important: If it any injury or o	33	21. Signature of Funeral Service of Inse	igev .	8	CHAIM CE  Name and Addr  900 REIS	ess of Facility S	07/2012   SOL LEVIN ROAD, PI	ISON &		INC.
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or confidence in Shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	dications that caused the decause on each line.  a. Due to (or as a cons	equence of):	OCAPD	in IN	FAREM		I (	Approximate Interval Between Onset and Death
be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	nnos NGLLI	us	<u> </u>			30 yr
To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of prediction of the control of	etal death 3	Ectopic pregnar Other (specify)	псу			Date of delivery	, ay Year
quires that the en signed by a	ted by Pł	Part II. Other significant conditions con  ALL HETMI  ARLEMAN	ntributing to death but not	resulting in the u	inderlying cause g	iven in Part I.				cause of death?
n: The law requires fifcate has been sig or, page 2 should b	<b>Completed</b>	AB Down	Aoppie	Awa				sy		y findings available bletion of cause of
ding Physician: th. After this certific	cate: To Be	ovaminar?	lospital:  1  Inpatient 2  28a. Date of injury  (Month, Day, Year)	28b. Time of	nt 3 DOA Ott	ry at	ome 5 Reside			בוטומט
oital or Attending Pours after death.  ral Director: After tilled in by the funers	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	cify)	eet, factory, office		28f. Location (St City or Town	, State)		
To the Hos within 24 hc To the Func	Medical	(Check 2 Medical Examin	cian: To the best of my knier: On the basis of examina e Practitioner: To the best	ation and/or invest	tigation, in my opin death occurred at 29c. Licens	ion, death occurred a the time, date and p se number	at the time, date an lace, and due to th	d place, and e cause(s) an	due to the cause	e(s) and manner state ted.
)		30. Name and address of person who co	_			0408	o Gm	11611 212	ک _30	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig		Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month :174 M 2012 Medical entenne acility Name (if not institution, give street and number) Examiner 4c. County of Death 4b City, Town, for Location of Death 7. Age (In yis. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours Director 1 M 2 F Jan. 30,1965 Maryland 27 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a, State 10b Count Director 10c. City, Town or Location 10d, Inside City Limits Saltimore NIA 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? MILTON 21200 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 8 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hyglene. Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Sanitation Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harol DAVIS Itendricks egina 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) coma Jones -molher 820 N. MILTON AVP Baltoinjury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Om -con 21. Senature of Funeral Service Licen-22. Name and Address of Facility Š 1101 Md.21229 Maro 23a. Let 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause Final disease or condition Approximate Interval Between Onset and Death Physician/ Due to (or as consequence of): Medical resulting in death) Examiner Preumeria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the buriai-transit Cause (Disease or injury that initiated events resulting in death) Last or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day signad by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Hoepital or Attanding Physician: The iaw requires 24 hours after death.
 Funsral Director: After this certificats has been signerly filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 1 1 🗌 Yes 25. Was case referred to medical Division of Vital 品 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No |@ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination articles in recongued as 3 Certifying Nurse Practitioner: To the best of my knowledge, death occur Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and title of certifier KES-000 3013 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Muthew Enn 31. Date filed (Month, Day Year) trar's Signatur State 10 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SON 7:58 PM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4b. City, 4c. County of Death BA WATE HOSPITA Security Number 7. Age (In yrs. last birthday) **Funeral** If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 216-22-1315 Min. **Director** M 2 DF 8 INIA permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 0 10e. Street and Numbe 10g. Citizen of What Country? Funeral 085 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 3- Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TOURS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) INON 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Çode) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -15-12 AKLAWN ( Funeral Service Licensee 22. Name and Address of Pacility 21. Sign 21224 Part 1 Enter the diseas shock, or heart failure. riplications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest, Approximate ist Interval Between Onset and Death Immediate Cause (Final Physician/ 5a disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and tra Due to (or as a consequence of): resulting in death) Last burial-1 attending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav Year Pregnant at time of death detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer. 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) RES-000C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANKLIN D 2123 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day September 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death he Johns Himore HOSPITA Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-68-5122 55 Director 1 ÅM 2 □ F 1957 Maryland July 12, th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Evaminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 🗗 Yes 2 🗆 No MD 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code Funeral 21239 5922 Glennor Rd. unk 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc δ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours efter **Black** 1 ☐ Yes 2 ☒ No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) plumber home improvement unk unk B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elaine Arrington Lindsay Forte Page 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5922 Glennor Rd; Baltimore, MD 21239 Heelth tem 27 i Elaine Forte - mother other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e
Department of F
Important: If ite
any injury or ot: Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Se Ronal 655 W. Baltimore St; Baltimore, MD 21201 Director 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed sate has been signed by the ettending physician and page 2 should be detached for use es the burlal-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending iniury work?
1 Yes 2 No 2 Accident after death Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 5 To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier valle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Baltimore Min TRANG 31. Date filed (Month, Day, Year) State barker Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Marylan		artment of H		and M			012	20671
			Registrar  1. Decedent's Name (F	First, Middle.	Last)		Cer	tificate of L	Jean		2. Date of De	Reg. No. 2	012	28674
	Physicia			MARY	FRENCH						Month Septem		Year 2012	3. Time of Death 9:10 A M
1	Medic Examin		4a. Facility Name (if no			nber)		4b. City, Town, or	Location of	f Death	o o p o o o		ty of Death	3.10 1.
1			Cherry Lar		sing Cent	cer		Laure	1			Pri	nce Ge	orge's
	Funeral		5. Social Security Num		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthp Count	lace (State or Foreign
	Director		218-03-937 Usual Residence of E		1 □ M 2 🛛 F i	97	Yrs.				March	3, 191	Ne	w York
	and show	tor		0b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary 28a-f otifie	Director	MD			Ва	ltimor	е					1	1XX Yes 2 ☐ No
	h the	al D	10e. Street and Number					10f. Zip Code				10g. Citizen o	f What Coun	try?
	ms 2%	Funeral	5245 St. C	harles			Link	21215				U.S.Z		
(0	er dea or ite niner	by Fu	<ul><li>11. Marital Status</li><li>1  Never Married</li></ul>	2 Marrie	Armed Fo	edent Ever in U.S proes? 2 <b>X X</b> No	5.   13. V	Vas Decedent of Hi FYes, specify Cuba	spanic Orig n, Mexican,	Puerto F	city Yes or No- Rican, etc.)		ace - America ack, White, e	
99	rs afte	ed b	3 🛛 Widowed 4 🛭		If Yes, Giv Year or Da	/e	1	☐ Yes 2XXNo	Specify:			Speci	fy: Whi	te
2-0	2 hou "natu	Completed	(Specifi	15. Decedent	's Education t grade completed)	)		lent's Usual Occupa		of workir		16b. Kind of	Business/Inc	iustry
7	thin 7	com	Elementary/Second		College (1		life. Do	O NOT use retired)	amy most	Or WORKII	rg		_	
0	ed wii Hygie other ent, th	Be (	17. Father's Name (Firs	st. Middle. La	st)		поше	maker	18 Mother	r'e Name	/Eiret Middle	Own I Maiden Surnai		-=-
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To	Michael Ru							Tes		iviaideri Surriai	ne)	
ary	should and M is mai	3	19a. Informant's Name	_	p (Type, Print)		19b. Mailin	g Address (Street a				r, City or Town,	State, Zip C	ode)
Σ	nd 2 s ealth a n 27 i er tra		William E.	Frenc	ch, Jr. /	son /	1	Granite				aryland		
ore	e 1 ar of He If iter		20a. Method of Dispos		3  Removal from	20b. F		sition (Name of natory or other place	e)	D	ate	20c. Location	- City or To	wn, State
Ē	tment trant: tant: jury c		4 Donation 5			Wes	t Arun	del Crema	atory	9/1	4/2012	Odent	on, M	aryland
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai	3	21. Signature of Funer	01 (1	ensee	/ M01053	22	Donaldson 313 Talbo	i Funt ott Av	eral Zenue	Home, Laur	P.A. el, Mar	yland	20707
			23a. Pard . Enter the shock, or heart fa	disease, or callure. List on	complications that only one cause on ea	caused the deatl	n. Do not ente	r the mode of dying	g, such as c	ardiac or	respiratory an	est,		Approximate Interval Between
P	hysician/	i a	Immediate Cause (Findisease or condition	al	Adul	t Failu	re to	Thrive					1	Onset and Death months
1	Medical Examiner		resulting in death)	- 1		(or as a consequ								
		er	Sequentially list condi		b. —	inced De (or as a consequ								years
	ted insit	Examiner	cause. Enter underlyin Cause (Disease or inju	ng K	50010	(or do d donocqu	ierioc ory.							
	be executed sician and burial-transit	Ex	that initiated events resulting in death) Las	ıt 💮	C. Due to	(or as a consequ	ience of):							
00	te be executed nysician and he burial-transi	dical			d									
687	certification of the contraction	Med	IF FEMALE:											
S X	requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria		23b. Was decedent pre in the past 12 mor	nths?	1 Live	come of pregna Birth 2 - Feta	I death 3	Ectopic pregnance	y				ate of delive	
Вох	the atter	ysic	1 Yes 2 N 9 Unknown	10	4 ☐ Pregi 9 ☐ Unkr	nant at time of c nown	feath 5∟	Other (specify)				IV	lonth	Day Year
О	requires that the been signed by the should be detach		Part II. Other significa	nt condition	s contributing to d	eath but not res	ulting in the u	nderlying cause give	en in Part i.		23e. Did to	bacco use cor	ntribute to the	e cause of death?
S,	ulres t n sign lid be	ed by	Celluliti	s Lowe	er Extrem	nity					1 🗆 🕆	res 2 X No	3 🗆 Prob	ably 4 🗆 Unknown
oro	v requ	olete									24a. Was a	an 24b		sy findings available
ec Yec	The law r	Completed									autop perfo 1  Yes	rmed?	prior to condeath?	npletion of cause of
<u>a</u>	certificate rector, pac		25. Was case referred t examiner?	to medical	I			26. Pla	ce of Death	(Check		21-1 NO	T Tes	Z EZ NO
5	hysician: this certific al director,	2	1 🗆 Yes 2 🔀 N	lo	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	r: 🚈 Nur	sing Hon	ne 5 🗆 Resid	ence 6 🗆 Ot	her (Specify)	
ָם <u>'</u>	Ing P	ate:	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	Pending	28a. Date (Mont	of injury th, Day, Year)	28b. Time of injury	28c. Injury work	?		8d. Describe h	ow injury occu	rred	
SIO	death death ctor: / y the	Certificate:	2 Accident 3 Suicide 6	Investiga	ot be	of Injuny - At ho	mo form etro	M 1 L ' et, factory, office	Yes 2 1		106 Lasation (0	A	h - u - u - D	Davida Alvantan
Division of Vital Records,	after after Direct din b		4 Homicide	determin		ng, etc. (Specify,		et, lactory, office		12	City or Tow	treet and Num n, State)	ber or Hurai i	Houte Number,
_ (	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 X	Certifying F	Physician: To the b	est of my knowl	edge, death o	ccurred at the time	, date and p	olace, and	d due to the ca	use(s) and mai	ner as state	d.
	the Full Type Fu	Med	(Check 2 ☐ only one) 3 ☐	Medical Exa Certifying N	aminer: On the bas lurse Practitioner:	is of examination To the best of m	and/or investi ny knowledge,	gation, in my opinion death occurred at th	n, death occ ne time, date	urred at t and plac	he time, date a e, and due to t	nd place, and d ne cause(s) and	ue to the cau manner as st	se(s) and manner stated. ated.
i	To t		29b. Signature and title	of certifier	2 - l	mn		29c. License	number			29d. Date sign	ed (Month, D	ay, Year)
									3411			Septem	ber 6	, 2012
1	11		30. Name and address Jagdish Sh		,	`		,	ne. Su	iite	205. R	owie M	(arv) a	nd 20715
	Stat	е	31. Date filed (Month, P			egistrar's gnat	bark	/			, D	,		-5 20,120
pro	Registra	ır	SEL T	0 2012	- Levery	· / /	7		_					

Patient Known as: BOLIAT, EUCENE P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 28675 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:35 PM Eugene R. Goliat September Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital of Bultimore Baltimore 9. Birthplace (State or Foreign Country)unk **Funeral** Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth Months Hours Min. (Month, Day, Year) **Director** 1 XM 2 F 87 Usual Residence of Decedent April 24, 3a or 28a-f shov t be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside Cify Limits **Baltimore** Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 2525 W. Belvedere Avenue Funeral 21215 USA 11. Marital Status unk ո "natural", or iten ledical Examiner r 12. Was Decedent Ever in U.S Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation UTIK
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) unk Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ည 19a. Informant's Name/Relationship (Type, Print) Department of Health ar. Important: If item 27 is: any injury or other trainone. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 W. Belvedere Ave; Baltimore, MD 21215 Sinai Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 to Other (Specify) in state Signal of Fundal Ser de Losen Francis Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line erval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial infarction Medical Due to (or as a consequence of) **Examiner** Coronary

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Medical certificate be Box 68760 98 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibr. 11-ti. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 24 hours after death. Funeral Director: After this certificate performed 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examinor? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 1 Natural injury 5 Pending Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number D59062 M.D. 2012

Registrar

DHMH 17 Rev 06-2011

State

2401 W Belvedere

egistrar's Signature

Baltimore MO

21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hanse

J.

31. Date filed (Month, Day, Year) SEP 1 0

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20   2   28											28676					
		1. Decedent's Name (First, Middle, Last)  hysician/ Medical  1. Decedent's Name (First, Middle, Last)  CATHERINE S. GUTHRIE  2. Date of Death Sept. 0								$^{ m ath}$	3. Time of 1:58		3. Time of Death 1:58 P M			
	Examin		4a. Facility Name (if							ocation of De	eath		- 1	. County of De		1
	Funeral	Director	Cherry La 5. Social Security Nu	Laurel				Date of Birt	9. E	Prince George's  9. Birthplace (State or Foreign						
	Director		226-28-8624 1 ☐ M 2 🖾 F  Usual Residence of Decedent				97 Yrs.	Months	Months   Days   Hours   Min.			Sept.1				y)
	yland f show ed at		10a. State	10b. County			ity, Town or Lo							•	10	d. Inside City Limits
	he Mar or 28a		MD 10e. Street and Num	Montgome nber	ery	S	ilver S	pring 10f. Zip Co	ode		_		10a Cit	tizen of What	Count	1 Yes 2xxNo
Maryland 21215-0036	s 23a oust be	Funeral	9617 Ea	st Light	t			2090					USA			,.
	ould be filed within 72 hours after death with the Maryland Id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed		Armed Fo	e		Was Decedent If Yes, specify	Cuban, I	Mexican, Pu	(Specify uerto Ric	Yes or No- an, etc.)		14. Race - Ar Black, Wh Specify: W	nite, et	C.
	in 72 hours e. han "natur e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5				(Give kind of work done during most of working life. DO NOT use retired)  Gov							Kind of Business/Industry Vernment Printing		
d 21	ed with Hygien other the	Be C	Downer							Name /F	Office ne (First, Middle, Maiden Surname)					
Baltimore, Marylan	permit. Page 1 and 2 should be fill Department of Health and Mental Important If Item 27 is marked of any injury or other traumatic evenones.	2														
			19a. Informant's Name/Relationship (Type, Print) Steven L. Johnson/Grandson					ng Address (Si						State, Zip Code)		
			20a. Method of Disp	osition	Removal from	20b.	Place of Dispo cemetery, crer st Arun	sition (Name on matory or other	of er place)	Se	pt.Date	6,	20c. Lo	ocation - City		n, State
Baltıı	permit. P Departm Importal any injur		21. Signature of Fun		nsee	ee 22. Name and Address of Facility Donaldson F					Fun	Funeral Home, P.A.				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate													Approximate Interval Between
-	Ph <sub>sician</sub> Medical		Immediate Cause (Final disease or condition resulting in death)  Arterosclerotic cardiovascular disease  Due to (or as a consequence of):  Onset and Death years											Onset and Death		
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	d d ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	injury	Due to	quence of):	nce of):									
	be executed sician and burial-transi	edical Ex	resulting in death) Last  Due to (or as a consequence of):													
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ROX	death ne atte ed for	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d.							23d. Date of o Month	Date of delivery Month Day Year					
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VItal	ician: certific rector	Certificate: To Be C	25. Was case referred to medical examiner?  Elemental:  26. Place of Death (Check only one)													
	nding Phys ath. r: After this e funeral di		27. Manner of Death 1 <b>XX</b> Natural 2 Accident		28a. Date (Mon:	1  Inpatient 2  ER/Outpatient 3  DOA  28a. Date of injury (Month, Day, Year)							pe how injury occurred			
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		3  Suicide 4  Homicide	nome, farm, str	me, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	the Funeral	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a cause 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a cause 2 Certifying Nurse Practitioner:									e caus	e(s) and manner stated.			
	Vith Vith Con		29b. Signature and t	itle of certifier	Leler	Sm	MD		3411					te signed (Mor cember		
7	1. 1		30. Name and addre	ess of person who					1				pept	,ciiiDCT	J,	2012
	(ρ V Stat		Jagdish 31. Date filed (Month	h, Day, Year)	32. F	4300 G	allant	Fox La	ine,	#205,	Bov	vie, M	D 20	715		
	Registra			SEP 10	2012	ensur	ature.	ares								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Paul William Ganoe, Sr. 12:15 p M September 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9031 Jefferson Street Savage Howard Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 233-34-5457 **Director** 1XXM 2 | F 88 West Virginia Oct. 27,1923 Usual Residence of Decedent fshow the Maryland notified at 10c. City, Town or Location Director 28a-f MD Howard 1 Yes 2XXNo Savage 10e. Street and Number ō 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral 9031 Jefferson Street 20763 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. rmed Forces?

XYes 2 No Black, White, etc. ō 1 Never Married XX Married Medical Examir þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Brick Mason 12th Ø Construction other of the and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ervin Lee Ganoe Aubrey Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Jean K. Ganoe/Wife Jefferson Street, Savage, MD 20763 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 9/11/2012 Gore, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, 20707 Laurel, ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, of heart failu Immediate Cause (Final Physician/ Advanced Congestive Heart Failure disease or condition years Medical resulting in death) Due to (or as a consequence of) **Examiner** Renal Failure 3 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) use as the burial-transi Arteriosclerotic Cardiovascular Disease 15 years Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical certificate be Diabetes Mellitus 5 years P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Year Month Other (specify) Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be Division of Vital Records, 1 Tes 2 X No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2XXNo 24a. Was an page 2 s has autopsy performed? Yes XX No certificate 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) To the Hospital or Attending Priyster within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral dire 1 Yes 2**X** No ည 4 Nursing Home 5 X Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 XNatural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

State

DHMH 17 Rev 06-2011

Registrar

(Check

29b. Signature and title of certifie

30. Name and address of person who cor

SEP 1 0 2012

MD

BG Manejwala,

31. Date filed (Month, Day, Year)

14201 Laurel Park Drive,

ed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laurel, MD

29d, Date signed (Month, Day, Year)

September 7, 2012

29c. License number

D13671

RIMES

State Registrar DHMH 17 Rev 06-2011

within 24 hours To the Fune completely fi

29a. Certifier

29b. Signature and title of certifier

MEENAKSHI

31. Date filed (Month, Day, Year)

Meenakihi

SEP 1 0 201

(M.D.)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAGAR

900 S. CATON AVE

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P-26615

BALTIMORE

29d. Date signed (Month, Day, Year,

M.D.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da SEPTEMBER Physician/ 2012 11:45 P M JULIA HIDARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 123-38-6684 1 □ M 2 🛛 F Yrs 100 01/09/1912 MD r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 7 SLADE AVENUE, #504 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify. 3 X Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. ?7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 11 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SOLOMON RHISTY RACHEL SHAMULA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 Is eny Injury or other trau RAE SWIRNOW/DAUGHTER 100 HARBORVIEW DRIVE, PH1A, BALTIMORE, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) UNITED HEBREW CEM. 09/06/2012 STATEN ISLAND, NY 21. Signature of Funeral Service Life vee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 bility disease or condition resulting in death) Medical Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending plant of for use as IF FEMALES 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year 4 Pregnant at time of death ed by the a q 1 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, disease Completed pankinsm 1 Yes 2 No 3 Probably 4 Unknown been sprin, decurity ular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy meditis After this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPUL မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Lun 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A completely filled in by the f Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 6 2012 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MON

31. Date filed (Month, Day, Year)

6701

2. Registrar's Signature

N. Charles

SF town MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gwaylon Leroy Hose State of Maryland / Department of Health and Mental Hygiene 2012 286											2868					
	R	1- For State Certificate of Death Registrar								- [2	Reg. No.  2. Date of Death  3. Time of Death					
Physician/ Medical Examiner	7	Gwaylon Leroy Hose Au										nth Day Year 2000 hrs				
	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Local								Death			4c. County of Washingt			
	5	Meritus Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last					Hagerstown thday)   If Under 1 Year   If Under 24H				8. Date	of Birth(	_	M/DD/YYYY) 9. Birthplace (State or		
Funeral Director		214–14–6877		K M 2 F 89			Yrs. Months				4		1922 Foreign Ma		Maryland	
	t	Jsual Residence of Decedent	IZE_IVI	,			1	<u> </u>	L	<u> </u>						
any	10a. State 10b. County 10c. City, Town or Location								Od. Inside City Limits							
and [show	L	MD Wa	Wil	Williamsport								Yes 2 <sup>X</sup> No				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: To see Completed by Funeral Director	1	0e. Street and Number 16605 Coney	Ct.				10f. Zip Code 21795				10g.	USA	t Country			
with 1 with 1 ms 23 ms 2	1	1. Marital Status		. Was Dec	edent Ever in U.				anic Origin				14. Race - White,		n Indian, Black,	
r death with or items 23must he no		1 Never Married 2 X	1	1 Yes 2 X No			If Yes, specify Cuban, Mexican, Puert					• •		T71		
s after ral",	: -	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X N or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup														
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5-0036 ed within 72 hour tygiene. he Medie I Exam Completed		8		0 c1			ck						grocer	ore		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medie-		17. Father's Name (First, Mide	lle, Last)					11					iden Surname)			
121 d be fil lental liental lental le		Charles Dani				10h Mailine	Addross	(Stroot					iffin er, City or Town	State 7	in Code)	
MD 21 d 2 should th and Me n 27 is ma numatic ex	1	Dernis W. H						,					IV 25428		, , , , , , , , , , , , , , , , , , ,	
and 2 and 2 lealth reem 2		20a. Method of Disposition		20b. Place of Disp			osition (Name of cemetery,			, -	Date		20c. Location - 0	own, State		
nore ages l nt of F t: If i		1 Burial 2 Crema		Removal fr	om State	crematory or ot	ner place	)								
Baltimore, bernit. Pages I ar Department of Hee Important: If ite		4 X Donation 5 Other 21. Signature of Funeral equ			Discontinu								omy Boa	Board		
	21. Since for Funeral/Service of															
Physician	1	23a. Part I. Enter the disease favure. List only one cau	ise on each l	line.			he mode	of dying, s	such as ca	rdiac or	respirato	ry arrest	t, shock, or hea	t	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disearce condition resulting in death			dural Hemato									_	Death	
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		events resulting in death). La	d	`		·										
2.   s = 3	5	UNPENDED	A	MENDED												
). Box 68760, the death certificate by the attending physic chef for use as the bur Physician/Mec		IF FEMALE: 3b. Was decedent pregnant		23c. If yes,	outcome of preg		etal death	3 [	Ectopic	pregnar	ncy		23d. Date of o	lelivery Da	y <b>Y</b> ear	
x 68 h certi tendin use as	2	past 12 months?	(4)		nant at time of		ther (Spe									
Boy e deat the at the at	<u>^</u>		11.1	9 Unkn	own		1. 1.7-		in Day	-41	1220	Did tob	noco use contrib	ute to th	e cause of death?	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burilloring Certification: To Be Committed by Physician/Med	Diabetes Mellitus: Hypertension: Seizures											permana				
ords, I w requires us been sig should be	2	Diabetes Wellitus,	Пурспеп	01011, 001	120100						24a.	Was an			psy findings available	
i of Vital Records, ing Physician: The law requires.  After this certificate has been signimeral director, page 2 should be in To Be Commileted.											1	autopsy	red? de	eath?	npletion of cause of	
Vital Rec ysician: The I his certificate I director, page		25. Was case referred to me	licat					26 Place	of Death (	Check of		Yes 2	<b>√</b> No 1	Yes	2 No	
Vital visicinm visicinm his certi	ŏ¦	examiner?		pital: 1	Inpatient 2	ER/Outpatien	t 3	-	A			5 🔲 R	esidence 6	Other:		
ding Phy L. After th funeral c	-t	1 ✓ Yes 2 No This impatient 2 ✓ Endougation 5 Don 1.    Natural 5   Paneline   28a. Date of Injury   28b. Time of Injury   28c. Injury at W   FOUND: 1   Yes 2   1   Yes 3   1   Yes 4   1   Yes 4   1   Yes 5   1   Yes 5   1   Yes 6   1   Yes 6   1   Yes 6   1   Yes 7   1   Yes 7   1   Yes 7   1   Yes 8   1   Yes 9   1   Yes 9							y at Work	at Work? 28d. Describe how injury occurred Subject fell						
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Division of Vital spital or Attending Physician tours after death.  neral Director: After this certified in by the funeral director.  Contification: To Be	<u> </u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.								28f. Location (Street and Number or Rural Route Number, City or Town, State) 16605 Coney Court, Williamsport, MD						
Dispital hours and recall of filled	3	4 Homicide	letermined	1	Outside in											
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i	<u>8</u>		g Physiclan Examiner: O	: To the be n the basis	est of my knowled of examination a	lge, death occu and/or investiga	irred at th ation, in m	e time, da iy opinion,	ite and pla , death occ	ice, and curred a	due to that the time	e cause , date ar	(s) and manner nd place, and di	as stated ue to the	r. cause(s)	
To the Ho within 24 To the Fu completel	<u> </u>	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date signed)														
		1 X randin	1,00	118			O.C.M.E.					September 5, 2012				
	-	30. Name and address of pe							-							
		Laron Locke MD.			al Examiner		altimor	e Stree	t, Baltim	nore, N	MD 212	23				
Stat Registra	te ar	31. Date filed (Month Day Y	0 201	2 32. 7	egistrar's Signat	A. 40	ale	/								

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 8 Physician/ SEPTEMBER ESTELLE VIRGINIA HECKROTTE 2012 10:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 4309 MEADOWCLIFF ROAD GLEN ARM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year /20/1931 1 M 2 1 F MARYLAND Director 81 214-26-7445 Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD BALTIMORE GLEN ARM 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21057 USA 4309 MEADOWCLIFF ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 XNo 1 ☐ Never Married 2 🛣 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY CROSSGUARD 8TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EDNA FERGERSON ANDREW B. DORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD C. HECKROTTE, SR./HUSBAND 4309 MEADOWCLIFF RD. GLEN ARM, MD20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State MORELAND MEM. PAR, 9/12/2012 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and De LIVER Physician/ Medical resulting in death) Examiner 2011 Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has 1 Yes 2 No certificate 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) filled in by the funeral director, examiner? Other: 4 Nursing Home 1 Tyes 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: : After 1 work? 1 🗌 Yes 2 🗆 No 1 Natural 5 Pending 24 hours after death Funeral Director: A Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 3 within 2 only one) Day, Year) 29b. Signature and ti 29c. License number 29d. Date signed (Month, MI 66058 0 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER DRIVE TOWSON, MD 21204 suite 303

DHMH 17 Rev 7/2009

State Registrar RICHARD MACKEY,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12-06750 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ RICHARD PM #14 2012 09 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MARYLAND GENERAL HOSPITAL BALTIMORE BALTIMORG 9. Birthplace (State or Fundamental) Mary land If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 🗷 M 2 🗆 F Hours Year 63 219-50-3190 1949 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland **Funeral Director** 1 Ves 2 □ No Marviard 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced "natural", Year or Dates. f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NGT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) aborci Be Nother's Name (First, Middle, Maiden Surname ည homas W. mant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Landsdowne 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. imate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 2. No certificate e Hospital or Attending Physician: The hours after death.
e Funeral Director: After this certificat oleted filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 X Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗷 Natural 5 Pending Accident Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 29c. License numbe M-0958 2012 09 Emmerce lyder. 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Registrar SEP 1 0 2012

EMMANUEL
31. Date filed (Month, Day, Year)

32. Registrar's Signature

KYEREME - TOAH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28683 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month KAREN DENISE EP 1820 M 06 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY HOWARD COUNTY GENERAL HOSPITA COLUMBIA 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 \( \text{M} \) 2 \( \text{F} \) If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Months Min 50 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Funeral Director notified Baltimore MD 28a-f 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Chape USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ural", or iter Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Consolidated 12th grade year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alvin Hull, Sr. Randolph Mattebell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 N. Chapel Street Baltimore MD 21231 Health a Mattebell Hull Mother Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) King Memoral Windsor Milly MD 21. Signature of Funeral Service Licensee Vaughn C. Greene Funeral SVCS Jan 8728 Liberty Fandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ACUTE FAILURE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit ENCEPHALOPATHY Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be exec. 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician ar Be Completed by Physician/Medical COAGULO PATHY Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Pregnant at time of death Year signed by the a d be detached for g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MUCOSITIS 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🗓 🗡 0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifie 29c. License number

0 State Registrar Mighti li

31. Date filed (Month; Bay,-Year) -

MYTHILY VANCHA, 11085

DHMH 17 Rev 7/2009

00064760

Little Patuxent PKWY, Suite Lool, Columbia

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d, Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla		artment of H		Viental Hy	giene Reg. No. 2 (	112	286	81
			Decedent's Name (First, Middle, Last)		inodio or b		2. Date of De	eath	<u> </u>	3. Time of De	eath
	Physicia Medic		Bernadette Hickman-Vinso	n			Month	27. 20	Year 112	12:31	P.
and a	Examir	er	4a. Facility Name (if not institution, give street and number)  3 First Light Court		4b. City, Town, or Rosed				ty of Death	е	
	Funeral			. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthp	place (State or F	oreign
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	yland •f sho ed at	ctor		City, Town or Lo					1	0d. Inside City I	
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920	s after al", or Exami	d by	1 Never Married 2 Married 1 Ses 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates.		1 ☐ Yes 2 No			Specif			
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ylan	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	은	Codell Hickman			Ara Lee			,		
Mar	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	nd Number or Rur	al Route Numbe	er, City or Town,	State, Zip C	(ode)	ij
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m 0	0 0 = =		1 Burial 2 Cremation 3 Removal from State	cemetery, crem	natory or other place Cremato	08/	20/12	oundall	-	Wil, Glato	
Baltimore, Maryland 21215-0036	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee		. Name and Address	-		-Harris		eralHo	ome
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of	on and/or investi	igation, in my opinior	n, death occurred a	t the time, date a	ind place, and di	ue to the cau	se(s) and manne	er stated.
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	2		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Pi	St Pa	iul P	1, Loth	FIRM	Ba	HIMOR	imi
	Stat	٠	31. Date filed (Month, Day, Year) SEP 1 0 2012	ure Sau	Kel	04: 1	1 7	11004	+	2120	4
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Tyrone Eugene Huff 30PM Medical 08/ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 701 Everist Drive Aberdeen Harford 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Director 220-50-2273 1 X M 2 □ F 64 07/21/48 Maryland 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examirer must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Harford Maryland Aberdeen 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 701 Everist Drive USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 3 1 Never Married 2 1 Married 1 ☐ Yes 2 🛛 No Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Masonry 12th grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Huff Helen Lucille Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Huff Everist Drive Aberdeen, Maryland 21001 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Inference of Inference 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Berkley Cemetery 09/05/12 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd. Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0 cm Medical Due to (or as a one ouence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical C Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate Yes 2 No 2 🗌 No 1 Yes funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital မ 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aff
d in by the fu 2 Accident М 1 ☐ Yes 2 ☐ No Investigation 6 Could not be completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital ( 24 hours Medical 29a. Certifier 1 Quertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20215 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601-5-Unia K. NAIR MD Colo 32. Registrar Signati State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 2012 Year Sept. Day BEVERLEY ANNE BAXTER **IZZO** 8:00 A M 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Hours 213-28-3462 Days Min. (Month, Day, Year) 1 - M 2 XX 83 Yrs Nov. 8, 1928 Canada Usual Residence of Decede 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2x No Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9107 Lilac Park Drive 20723 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 TNo
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mid-South Elementary/Secondary (0-12) College (1-4 or 5+) yrs Bookkeeper Building Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Baxter Mabel Beaulac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Izzo 9107 Lilac Park Drive Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowrdige Mem PK. 9/11/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Surviv 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland M00770 20707 23a. Part 1. Enter the disease, or shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death FAILURE Immediate Cause (Final RESPIRATORY SECONDARY disease or condition resulting in death) Due to (or as a consequence of): ASPIRATION PNEUMONIA Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ESOPHAGEAL DYSMOTILITY 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "naturals", or items 23a or 28a-f show any hipuy or other traumatic event, the Medical Examiner must be notified at any hipuy or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

burial-transit and attending physician certificate be the as use ō The law requires that the death detached been signed to should be deta page 2 s has After this certificate director,

Box 68760

P.O.

of Vital Records,

Division

410 STROKES 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform performed? DEBILITY 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) 1 ☐ Yes 2 🗷 No HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D72139

To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur

State

Registrar

Q. ABBAS MD SYED 31. Date filed (Month, Day, Year)

(Check only one) 29b. Signature

> 6336 CEDAR

d address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 10:39 AM Katara Alva Frances Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death aurel Regional Hospita Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours Min. (Month, Day, Year) Director 212-92-7783 1 □ M 2 🖺 F 34 Yrs. Oct.10,1977 MD Usual Residence of Decedent show at 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f 1 Yes 2XXNo Anne Arundel Laurel 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral . Page 1 and 2 should be filed within 72 hours after death with 3396 Fountain Green S. 20724 USA ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 X Never Married 2 Married Yes Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2XX No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates American Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Caregiver Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leon Aubrey Jones Yvonne Evelyn Dedeaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon A. Jones/ Father 3396 Fountain Green S., Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 9/10/2012 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Kein Skila M01053 313 Talbott Ave., Laurel, 23a. For 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 35 minutes Physician/ Ventricular disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ocardial Infarction 80 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Cardiovascular Disease burial-transit pertensive unKnown that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should he hatached for the contractor. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ End Stage Renal Disease on Dialysis 1 Yes 2 No 3 Probably 4 Unknown Thrombotic Thrombocytopenic 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 N Seizure Disorder 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

(Check only one)

29b. Signature and title of certifier

Wang Koon

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurel

M.D

Hospita

Regional

Pegistrar's Signature

D16605

7,300 Van Dusen

Emergency I

29d. Date signed (Month. Day. Year)

Road

aul Linwood Jo		1- For State	of Maryland	/ Depai	rtment of tificate of	r Health ar	nd Mental	Hygiene		<b>8.</b> 20	12 2868			
Physici		Registrar  1. Decedent's Name (First, Middle, La	st)		inouto or	Dodin		2. Date of D	Reg. No. eath		3. Time of Death			
Medical Exami		Paul Linwood 3	Jones .Jr.					Month Septem	Day ber 2, 2	Year 2012	0036 hrs			
		4a. Facility Name (if not institution, gi				4b. City, Town, o	r Location of Dea			c. County of D	Death			
		5819 Farmview Avenue				Baltimore				Baltimore (				
Funeral Director		5. Social Security Number 6. S 215-90-7552	Sex 7. Aς ΔM 2 F 48	ge (In yrs. la:	st birthday) Yrs	Months Da		8. Date of 12/2		1-	o. Birthplace (State or or oreignMaryland Country)			
sus.		Usual Residence of Decedent  10a, State 10b, County		10c City 1	Town or Locat	ion					10d. Inside City Limits			
<b>E</b>		Maryland			timor						1 X Yes 2 No			
ryland a-f shu f nuce.	형	10e. Street and Number				10f. Zip Code			10a Cit	izen of What				
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked nther than "natural", or items 23a nr 28a-f shu ent, the Medical Examiner must be notified at nace.	Il Director	4605 White Ave				21206			USA					
ith wi	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Deceden			s Decedent of H es, specify Cuba			No-	14. Race - A White, e	merican Indian, Black, tc.			
er dea	큔		1 Yes 2 d If Yes, Give Year	X No	1	Yes 2 X No	n enecify:			Specify: B	lack			
irs aft tural"	ģ	15. Decedent's Education (Specify of	or Dates:	npleted)		t's Usual Decupa		of work done	16b.	Kind of Busin				
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or		_	ost of working life	e. DO NOT use r	etired)	uction					
5-0036 led within 72 h Hygiene. nther than "n.	휠	12th grade			Labo:	rer								
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21215-0036 nuld be filed within 7 Mental Hygiene. marked uther than	8							llen Amos						
D 2 should ris m	٤	P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Darlene Jones 1659 Essextowne Circ												
nore, MD 2 ages 1 and 2 shou nt of Health and N it: If item 27 is n uther traumatic	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date									20c. Location - City or Town, State				
Baltimore, Nemit. Pages I and Department of Health Important: If item injury or nother trau		1 Burial 2 Cremation 3	Removal from St			mlaaa\					,Maryland			
ti Pag ti Pag timeni rtanti		4 Donation 5 Other Specification of Funeral S. Vis. Lice	/: 	Ва										
Baltimo permit. Page Department of Important: injury or ntl		alle Har	nsee		42	10 Rela	air Rd.	atman- Baltin	-наг ore	ris r .Marv	uneral Home land 21206			
Physician		23a. Part I. Enter the disease, or com		the death, I							Approximate Interval			
/Medical Examiner		failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	Hypertens			scular	Disease				Between Onset and Death			
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nted d ansit	۵	events resulting in death) Last	·	equence or).	•									
<b>0,</b> e be executed //sician and burial - transit	Physician/Medical		AMENDED#1,			,per me	,g932 10	0-11-12						
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the burn	Z	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ne of pregna		tal death 3	Ectopic preg	nancy	230	d. Date of del Month	ivery Day Year			
X 6 th cer ttendi	흥	past 12 months?  4 Pregnant at time of death  5 Other (Specify)							W					
b.O. Bo that the deat ned by the at detached for	ڇ	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
F, P.O. ires that the signed by I be detache	<u>8</u>		-	n but not res	suiting in the u	nderlying cause	given in Part I.				e to the cause of death?  Probably 4 Unknown			
S, F quires en sig	te d	Chronic Alcohol	L1sm					24a. Wa			e autopsy findings available			
cords, law requir has been s	B		<del></del>					aut	opsy		to completion of cause of			
Rec The I cate I	ĕ	Chronic Alcoholism  1 Yes 2 No  24a. Was an autopsy performed? 1 Yes 2 No								o 1 🗸				
Vital   ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Hospital:				e of Death (Chec							
27 Manner of Death 1289 Date of Injury 128h Time of Injury 128c Injury at Work? 128d Describe										other: Scene				
ion of tending Pheath. tor: After the funeral	흥	1 X Natural 5 Pending	28a. Date of Inju (Month, Day,)	ear)	ZOD. TIME OF II		Yes 2 No	20d. Describ	e now mje	ary occurred				
Sio	Eat	2 Accident Investigat	28e Place of Ir	iury - At hon	ne farm stree	t, factory, office		28f Location	(Street a	nd Number o	r Rural Route Number, City			
Divising pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not determine	De	,,	,,	,, 140.01), 1	anang, oto	or Town			Train Train Trainson, only			
Division To the Hospital or Atten within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one) 2 Medical Examine				red at the time, d								
To t with To t	Medical	29b. Signature and title of certifier	and manner stated			29c. Licens					(Month, Day, Year)			
		///	\		-	O.C.				tember 2,				
00115	}	30. Name and address of person who	completed cause of c	leath (Item 2	23a)									
OCME			puty Chief Medi			W. Baltimore	e Street, Balt	imore, MD	21223					
S	ate	31. Date filed (Month, Day, Year)	32. Pegistra	r's Signature	9	•								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Month <u>Eric</u> King September 2012 Dennis 4:40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Union Bridge 10239 Fountain School Rd. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yeb. 19) Months 1 🕱 M 2 🗆 F Maryland 219-74-7868 51 1961 Director Feb. Usual Residence of Decedent 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Union Bridge Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 21791 U.S.A. 10239 Fountain School Rd. . Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. Fant, If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \sum No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1981–86 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 2 senior technical engineer business machines mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Louis King Caroljeanne Mary DuVall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Bridge, MD 21791 10239 Fountain School Rd. Connie King/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Important: If ite any injury or otl cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winters Cemetery 9/6/2012 nr. New Windsor, MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. 21. Signature of Funeral Service Licenses att New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Due to (or as a consequence of): Exam Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death
Unknown detached 9 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be the funeral director. 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\mathbf{X}$  Residence 6  $\square$  Other (Specify) Hospital 2 WNo ပု 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Investigation after death Director: Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

DHMH 17 Rev 7/2009

State Registrar

within 2 To the I

(Check

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Fludhud IMD

468 Thomas Tohyson Dr. Ste Zoo Frederick mp 217

31. Date filed (Month, Day, Year)

SFP 1 0 2017

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 23 ay 2012 ear Keefe Georgeanna Μ. 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death First in Quality Care Asst. Living Waldorf Charles . Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 2 X F Days Hours April Day Year) 1917 336-01-6617 Director 95 Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Ohio 1 X Yes 2 □ No Cuyahoga Lakewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1246 Nicholson Ave. 44107 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 ₺ Widowed 4 □ Divorced If Yes, Give Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Private Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Clarence Teslik Anne Neuman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1246 Nicholson Ave., Lakewood, OH 44107 Jackie McLucas (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Cross Cemetery 8/31/2012 Cleveland, OH 21. Sign ture of F neral Service Lice see 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury) Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Day Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director, After this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 💆 Natural 5  $\square$  Pending injury 2 No Accident Investigation 1 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D28352

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person

32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

P 1 0 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vanessa C. Knight 1:30 ам 2012 Medical 4a. Facility Name (if not institution, give street and number)

Joseph Richie Hospice Examiner 4b. City Town, or Location of Death Baltimore 4c. County of Death 5. Social Security Number 216-62-8517 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD Months Days Hours Director 1 M 2 X F 56 11/22/54 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo N/A Baltimore 1 Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 2290 Lowell Ridge Rd -Apt F Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married δ African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates Amer 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Laborer e 1 end 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, 姓 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive Edges Samuel Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2290 Lowell Ridge Rd #F, Balt., MD 21234 permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is eny injury or other trau April M.Brown/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Mt. cemetary, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/13/12 Balt., MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Close F.Svs,PA,MD 21206-5105 22. Name and Address of FacilityHari P 5126 Belair Rd, Balt., MD 23a. Part 1/ Enter the disease, or complications that caused shock, or heart failure. List only one cause on a ch line. <del>,</del> or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Supernitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. anosoa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 🔲 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 112 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Mann f Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending injury I Director: A Investigation
6 Could not be determined Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Na 31. Date fil 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09-06-2012 Jack Lichtman Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery . Social Security Number Sex 1X M 2 D 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Czechoslovakia Director 101-14-9786 89 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville 1 🗆 Yes 2 🔽 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road #337 North 20853 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes. Give Specify 3 

✓ Widowed 4 

☐ Divorced Specify: Year or Dates. WWII White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Diamond Dealer Diamond Business traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental H. Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Pinchas Lichtman Miriam Oestreicher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Feuer - daughter 5813 Tanglewood Drive, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Spring field Gardens -1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 09-09-2012 Queens, New York Montefiore Cemetery 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 800 New Hampshire Ave. Silver Spring. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CERE Onset and Death BRAL 1 HR OMBOSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>\*</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MON 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 1 0 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $20\,$  [ 2Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29, Day 2012 Geraldine Capps Lovelace 2:40A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Montgomery

9. Birthplace (State or Foreign Country) Gaithersburg 8. Date of Birth (Month, Day, Yea OCT . 21 Age (In yrs. last birthday) If Under 1 Year If Under: **Funeral** 1 🗆 M 2 💢 F Days Hours 463-18-4183 94 Yrs. Min Director Texas Usual Residence of Decedent 28a-f show 10b. County 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Montgomery Gaithersburg ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 20877 108 Billingsgate Lane Jnited States of America hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc ò 1 Never Married 2 Married δ Maryland 21215-0036 Specify Caucasian permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examonee. 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates Completed 3 🖾 Widowed 4 🗌 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Jane Roberts James Capps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Billingsgate Lane, Gaithersburg MD 20877 <u> Janis Schmidt - Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Ft. Lincoln Crematory 09/04/2012 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee MO1294 Wh 1040 Rockville Pike, Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 nset and Death Metastatic ovarian carcinoma Ph. sici\_n/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 t phys attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No be detached for Month Day Year Pregnant at time of death 9 Unknown Part <mark>II. Other significant conditions c</mark>ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27, Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

only one)

3 🗌

1. Robert Birschbock MB,

14.20BERT BIRSCHBACH, M.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print 20 / Russel

istrar's Signature

29b. Signature and title of certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

64ITHERSBURG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 28A-F, PER ME G931 9 / 20 / 12 TRT

State of Maryland / Department of Health and Mental Hygiene For State Registrar 28694 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SEPTEMBER 5 2012 GILBERT LEVY 09:36PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Min. (Month, Day, Year) Director 219-22-9606 1 X M 2 □ F 85 04/23/1927 MD 28a-f shov 10b. County in than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2331 OLD COURT ROAD, 21208 #309 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ۾ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CHRISTMAS PROMOTIONAL Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygie filem 27 is marked other rother traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If Item 27 is mediany injury or other. ည SAMUEL LEVY REBECCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2331 OLD COURT ROAD, #309, BALTIMORE, MD 21208 DEBORAH LEVY/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 09/07/2012 4 Donation 5 Other (Specify) REISTERSTOWN, MD 21. Signatur of Funeral Service User see 22. Name and Address of Facility  $SOL\ LEVINSON\ \&\ BROS.$ , INC. nuger 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner piration A5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ATION APPROVED BY MEDICAL EXAMINER sician and burlal-transit that initiated events Due to (or as a consequence of) resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be ex 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician letely filled in by the funeral director, page 2 should be detached for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 🗌 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Llok 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐MNo 28d. Describe how injury occurred SUBJECT CHOKED ON BOLUS OF FOOD 1 Natural 5 Pending FD 8:30 № /5/12 FD 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 1 1 5 MELROSE AVE BALTIMORE, MD determined NURSING HOME Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Top for ble T, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 700 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

12-06691 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William P. Lynch State of Maryland / Department of Health and Mental Hygiene 2012 28695 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day September 4, 2012 Medical Examiner 1629 hrs William Patrick Lynch 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 99 Gambrills RD. Anne Arundel If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Director 1 X M 2 F Country) Yrs 1942 220-38-3502 Aug. 2, 70 Usual Residence of Decedent iny 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No 28a-f show timore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, are usurial, or items 23a or 28a-f show other transmite event, the Medical Examiner must be notified at once. Anne Arundel Severn Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 99 Gambrills Road 21144 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race · American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? White, etc. Yes 2 X No If Yes, Give Year 4 Divorced 1 Yes 2x X No specify: Specify: White ð 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Police Officer Washington D.C. 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Wilbur Joseph Lynch Kathryn Mary Toomey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Lynch/Son 1142 Little Magothy View, Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Pages
Department of
Important: 1 9/7/2012 Odenton, MD 4 Donation 5 Other Specify. West Arundel Crem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Donaldson Funeral Home, former a M01103 313 Talbott Avenue, 20707 Laurel, MD 23a. Part/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease aAtherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last has been signed by the attending physician and 2 should be detached for use as the burial - transit Physician/Medical x AMENDED 23a,27, per #4a, per me, g932 9-14-12 smX UNPENDED Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page this certificate Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No hours after death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24] Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E September 5, 2012 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (MorSEP 32. Resistants Signature State

DHMH 17 Rev 1/2001 **OCMF 2006** 

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		1- For State Registrar		tificate of Dea	nth	Re	eg. No.	
Physicia Medical Exami		Decedent's Name (First, Middle	laurice McCo	<i>Y</i>		2. Date of Death Month Septembe	Day Year	3. Time of Death 0319 hrs
		4a. Facility Name (if not institution University Hospital	, give street and number)		, Town, or Location of imore	Death	4c. County of Deat	A
Funeral Director		1 1/-	5. Sex 7. Age (In yrs. la	st birthday) If Un Mon	ths Days Hours	24Hrs. 8. Date of Birt	Foreign	rthplace (State or gn gn puntry) Many land
land f show any pace.	or	10a. State 10b. County  Maryland	NA 10c. City,	Town or Location	Baltimo	re		10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show sat be notified at once.	Il Director		ns Falls Parku	vay	212-16		og. Citizen of What Cou	A
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ant of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28s-7 sho or other traumatic event, the Medital Examiner must be notified at once.	by Funeral	3 Widowed 4 Divo	12. Was Decedent Ever in U.S  Armed Forces?  1 Yes 2 No  roced If Yes, Give Year  or Dates:	If Yes, spec	cify Cuban, Mexican, F		White, etc. Specify: <b>Bl</b>	rican Indian, Black,
036 rithin 72 hours ene. or then "natur dedical Exam	Completed	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade completed)  College (1-4 or 5+)	16a. Decedent's Usua during most of w	orking life. DO NOT u		16b. Kind of Business/	•
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	8	17. Father's Name (First, Middle, L Vincent Ma	Coy		Judi		yper	
ore, MD 21215-00; es I and 2 should be filed withi of Health and Mental Hygiene. If item 27 is marked other ti	۵	19a. Informant's Name/Relationshi Tudi Hu McC  20a. Method of Disposition	oy -mother	19b. Mailing Address 3913 C	hatham R	er or Runel Route Num Date	Battime  20c. Location - City or	zip Code)
Baltimore, permit. Pages 1 as Important: It ite injury or other ti		1 Burial 2 Cremation 4 Donation 5 Other Spe 21. Signature 9 Ineral Service I	3 Removal from State	rematory or other place		9/12/12	Catonsville neval Hom	Maryland EPA 21229
Physician /Medical	1	failure. List only one cause o			of dying, such as car	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wound of Back  Due to (or as a consequence of b.					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of					
execui	Medical E	UNPENDED	d AMENDED					
Sox 68760, leath certificate be attending physici for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant at time of dea	2 Fetal deat		pregnancy	23d. Date of deliver Month	y Day Year
, P.O. B res that the d	2	Part II. Other significant condition	ns contributing to death but not re	sulting in the underlying	ng cause given in Part		bacco use contribute to	
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was a autops perform	sy prior to o med? death?	utopsy findings available completion of cause of
Vital F sysician: this certifi director,	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	26. Place of Death (C	heck only one) Nursing Home 5 7	Residence 6 Other	r.
ion of tending Pl eath. tor: After the funeral		27. Manner of Death  1 Natural 5 Pendir 2 Accident Investi		28b. Time of Injury 0224 hrs	28c. Injury at Work? 1 Yes 2 ✓ N	Subject shot	ow injury occurred	
Division of Vital Rec Within 24 hours after death. To the Funeral Director: After this certificate b completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could determ	not be 28e. Place of Injury - At ho		ry, office building, etc.	or Town, St		ıral Route Number, City
Di To the Hospital within 24 hours 4 Worthin 24 hours 5 To the Funeral completely filled	Medical (	101100110111	rsician: To the best of my knowledg Iner: On the basis of examination an and manner stated.					
	¥	29b. Signature and title of certifier	pr		9c. License number O.C.M.E.		29d. Date signed (Mo. September 8, 20	
		Russell Alexander MD.	Assistant Medical Exam	iner 900 W. Ba	altimore Street, B	altimore, MD 212	23	
Sta Regist		31. Date filed (Month, Day, Year)	32. registrar's Signatur	pares				
DHMH 17 Rev 1/20	01			ORIGINAL			Ocus	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month C Physician/ Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death Tate Chesapeake Hospice House Linthicum Anne Arunde1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** Z. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Director 578-84-8625 1 M 2 54 1958 Washington, DC 27 is merked other than "netural", or Items 23a or 28e-f show treumatic event, the Mexical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1450 Washington Avenue 21144 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Heeith end Mantei Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Hahn Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 2 William Hoff Mary Elizabeth Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. McVearry / Husband 1450 Washington Avenue Severn, Maryland 21144 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I cemetery, crematory or other place) 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Sept. 2012 4 Donation 5 Other (Specify) Arundel Crematory Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Pand Odenton, Maryland 21 Signature of Meral Service Li 234 Part 1 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Betw nset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician; The iew requires that the deeth cartificate be executed ettending physician end for use es the buriei-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day signed by the e 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Hiknown pege 2 should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 1 Tyes 25. Was case referred to medica Division of Vital funerei director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ျှ 1 🗌 Yes 2 🖳 № 1 Inpatient 2 I ER/Outpatient 3 I DOA 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of HOUSE 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending n 24 hours eftsr deeth. e Funeral Director: Afte pietely filled in by the fun 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospitel Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 hor To the Fune completely fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Mogth, Day, Year) 18 cause of death (Item 23a) (Type, Print) 101 32. Registrar's signatur State Registrar

DHMH 17 Rev 06-2011

			For State Registrar	State of Marylar	d / Depa <i>Cer</i>	rtment of H	ealth and N Death		giene2 Reg. No.	012	28698
			Decedent's Name (First, Middle, Last,					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Levi	MITCHELL				9	10.00	ounty of Death	3:06 PM
13	Examin	er	4a. Fecility Name (If not institution, give	1 1 1-1		4b. City, Town, or	Location of Death			altimo	re
Ī	Funeral Director		5. Social Security Number 6. Security Number 1217-68-0882			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 02/02	th v, Year)	9. Birthp Coun	ace (State or Foreign try)
	p .		Usual Residence of Decedent  10a, State 10b, County	10c Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	anyla ed et	5	Maryland Balti		vson	oution.					1 ☐ Yes 2X No
	the N	rect	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cour	try?
	h with	al D	1 Fellowship Co	urt Apt.A		21286			USA		
٥	be filed within 72 hours atter death with the Maryland tal Hyglene d other than "natural", or Items 23a or 28a-f ehow event, i're Medical Exatra increust be notified at	y Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in L Armed Forces? 1 Yes 20 No If Yes, Give	-	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2☑ No	ispanic Origin? (S) in, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		. Race - Americ Black, White, pecify: Bla	etc.
21215-0036	hours tural',	ed by	3 Widowed 4 Divorced	Year or Dates:	16a, Dece	lent's Usual Occup	ation		16b. Kind	of Business/In	dustry
7	nin 72 n "na	Completed	(Specify only highest grad		(Give	kind of work done OO NOT use retired	during most of wor	king		1 7 7	
212	filed with Hygiene. other than	Com	11th grade		Disab	oled			Disa		
ng	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)  Levi Thomas Mit	taball Cr			18. Mother's Nan Agnes	ne (First, Middle	, Maiden Si	umame)	
Maryland		ို	Levi Thomas Mi		19b Mailir	ng Address (Street		rai Route Numb	er, City or 1	Town, State, Zip	Code)
<u>a</u>	tra fr		Corrin Mitchel			Box 167		imore,			
ē,	s 1 ar f Heal item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place	nal i	Date		ation - City or To	
altimore,	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ i 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State O	aklawn	Cemete	ry 09/0	7/12	Balt	imore,	Maryland
Balti	permit. Pages 1 am Department of Heali Important: If item 2 eny injury or other once.		21. Signatur of uneral Service Licent	asri		Name and Address					eral Home 06
•	Physician /Medical Examiner	_	23a. Pert 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ne cause on each line.	101011	er the mode of dyir		c or respiratory a	irrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed to attending physician and ed tor use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):						
.O. Box	he death certific r the attending p ched for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preging the street of the street	al death 3	Ectopic pregnanc Other (specify)	у		23	3d. Date of deliv Month	ery Day Year
<u>α</u>	juires that the de n signed by the a lid be detached t	þ	Part II. Other significant conditions co		Sulting in the u	inderlying cause gr	ven in Part I.		tobacco us		the cause of death?
Records,	The law requires that the ale has been signed by the page 2 should be detache	Completed						24a. Wa auto per 1 🗆 Yes	s an opsy formed? 2 No	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			0.1	26. Place of De				
of	ng Physician: tter this certitic ineral director,	2	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	ry at	dome 5 Res 28d. Describe			(fy)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				Yes 2 No	28f. Location City or To	(Street and own, State)	i Number or Rui	al Route Number,
_	e Hospital 24 hours a e Funeral D letely tilled i	edical Co	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s)
_	To the within 2 To the comple	Med	29b. Signature and the of certifier		M.	29c. Licen	se number		29d. Date	signed (Month	, Dey, Year)
1	- > - 0		1/1m		//	1	005521	13		9/1/13	
			30. Name and address of person who	completed cause of death (It	em 23a) (Type	, Print)	n 1-1	. 2		Mari	1 7/22
			31 Date filed (Month, Day, Year)	32. Registrat's Sig	nature	U OO W	Bolt nere	72 Del	TIPUL	1984/A	1 (115
	St Regist	ate rar	SEP 1 0 2012	Enema d.	barker	4				,	

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 2

			State Registrar	,	Certificate of D	Death	Reg	. No. 2012	28699
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Adeline Kathleen	MacLenn	ıan		2. Date of Death  Month  September	. Day 2012	3. Time of Death 6:34 AMM
	Examin		4a. Facility Name (if not institution, give street and number)  Emeritus at Potomac		4b. City, Town, or Rockvi			4c. County of Death	
	Funeral Director		138-12-2276 1□M2¬F	e (In yrs. last birthd 91 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec 5, 1	920 New	pplace (State or Foreign ntry) Jersey
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ral Director	Usual Residence of Decedent	10c. City, Town o			1	g. Citizen of What Cou	10d. Inside City Limits  1 ☑ Yes 2 ☐ No intry?
9600	urs after death wi tural", or items 2 al Examiner mus	ted by Funeral	11. Marital Status  1  Never Married 2  Married   12. Was Decedent Armed Forces?  1  Yes 2  Yes 2  Yes Armed Face of the Status Armed Forces?		13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	cify Yes or No-	14. Race - Ameri Black, White,	
Baltimore, Maryland 21215-0036	within 72 ho giene. er than "na the Medic.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 9 4	(G	ecedent's Usual Occupa Give kind of work done di e. DO NOT use retired) retary/Cont	uring most of worki	ng	b. Kind of Business Ir	
yland	d be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) George Sidney Jeffers	·			e (First, Middle, Maio Jeffers		
, Man	nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Barbara Spalholz - Niece	1	Mailing Address (Street a 1832 Goya D			ty or Town, State, Zip 20854	Code)
timore	permit. Page 1 a Department of H Important: If itel any injury or ott		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Doration 5 ☐ Other (Specify)	cemetery,	risposition (Name of crematory or other place nnent Cemet	ery 9-12	-2012 M		New Jersey
Ba	Depar Impor any ir		21. Signature of Funeral Service Licensee	٥	22. Name and Addres			an Funera exandria,	
	h si ian Medical Examiner	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linijury that initiated events	e. Cemia a consequence of): e Myocard	ial Infarct		r respiratory arrest,		Approximate Interval Between Onset and Death
9	death certificate be executed he attending physician and ed for use as the burial-fransit	Physician/Medical F	Breas d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ XNo  Breas d.  23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal death	3	у		23d. Date of delive Month	rery Day Year
P. O.	requires that the death cer been signed by the attendi should be detached for use	by Phys	9 Unknown  Part II. Other significant conditions contributing to death by	ut not resulting in t	the underlying cause give	en in Part I.		co use contribute to t	
Records,	The law ate has page 2	Completed					24a. Was an autopsy performe	24b. Were auto	obably 4 Xunknown opsy findings available ompletion of cause of
Division of Vital Records,	ending Physician: The sath.  7: After this certificate the funeral director, pag	Certificate: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	ent 2 ER/Outpa ry 28b. Tim inju	atient 3 DOA Othe	at		Assi e 6 Other (Specifi njury occurred	sted Living
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		building, etc	c. (Specify)	, street, factory, office		City or Town, S		ŕ
	the Hosp thin 24 hor the Fune mpleted fi	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	xamination and/or ir	nvestigation, in my opinion ge, death occurred at the	n, death occurred at time, date and plac	the time, date and p e, and due to the car	lace, and due to the cause(s) and manner as s	ause(s) and manner stated. tated.
	5 2 4 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8		29b. Signature and title of certifier		29c. License R116	833	9	Date signed (Month, -6-12	Day, Year)
	171		30. Name and address of person who completed cause of d Lemoil Johny, CRNP			Road Rocl	kville, M	D 20850	
	Stat Registra		31. Date filed (Month, Day, Year) SFP 1 0 2012	ar's Sanature	Mar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25tate of Maryland / Department of Health and Mental Hygiene

2012 28700

		1- For State Cell Registrar	rtificate of Death	Reg. No.	, , , , , , , , , , , , , , , , , , , ,
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day Year	3. Time of Death
ledical Exam	ner	Robert Lee Parken  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	Month Day Year September 5, 2012	1200 hrs
		151 North Linwood Ave	Baltimore	Jan Joan, or	5-0411
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la			9. Birthplace (State or
Director		220-94-7176 1 M 2 F	44 Yrs. Months Days Hours	Min. 7-4-1968	Foreign MARYLand Country)
y.		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
l ow any			Baltimore		1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-7 sho traumatic event, the Medical Examiner must be notified at once.		151 North Linwood ANE	21224	US	A
ath with terms 2:	neral	11. Marital Status 12. Was Decedent Ever in U. 1 Vever Married 2 Married Armed Forces?	.S. 13. Was Decedent of Hispanic Origin?  If Yes, specify Cuban, Mexican, Pue		American Indian, Black, etc.
fter de i", or i	리	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: (	Black
ours al atural	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b. Kind of Bus	
17215-0036 Id be filed within 72 hou fental Hygiene. arrived other than "matevent, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Labor	Constru	vetion
withii withii giene. her th	E	17. Father's Name (First, Middle, Last)	,,	ame (First, Middle, Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene, marked other than	Be C	Robert Lee Parker SR.		-Ley Sills	
D 21215-00; should be filed with and Mental Hygiene 7 is marked other ti	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	or Rural R ute Number, City or Town,	
MD id 2 shoulth and in 27 is		Shirley tarker	151 N. Linwood	Are. Backs. Wo	1.21224
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		20a. Method of Disposition 20b. I  Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, TenGARMETer PGEMETERY		City or Town, State
Baltimore, sernit. Pages I as Department of He Important: If ite injury or other ta		4 Donation 5 Other Specify:	22. Name and Address of Facility	/15/12 Balto.	me
Balt permit. Departi Importi injury		21. Signatur pel Fune Servic Licensee	22. Name and Address of Facility	Are Balto. M.	d. 21217
Physician		23a. Part I Enter the disease, or complications that caused the death			t Approximate Interval
Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Congestive Heart Failur	re		Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence or	of):		
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Hypertensive Cardiovas Due to (or as a consequence o			
	를	cause. Enter Underlying Cause (Disease or injury that initiated			
ansit de fur	Examin	events resulting in death) Last Due to (or as a consequence o	f):		
760, cate be execut	Medical	UNPENDED AMENDED			
760, icate be physicithe buri		IF FEMALE: 23c. If yes, outcome of preg 23b. Was decedent pregnant in the		23d. Date of d	•
Sox 68 leath certifi	cian	past 12 months?	2 Fetal death 3 Ectopic pre	gnancy Month	Day Year
Box 68' e death certifi	Physician	1 Yes 2 No 9 Unknown 9 Unknown	o liter (openiny)		
ires that the signed by a detached	by P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	
S, F quires t en sign ald be e	Be	Obesity			Probably 4  Unknown ere autopsy findings available
Cords, law requir has been s	Completed			autopsy pri	or to completion of cause of eath?
tal Rec	ပ်			1 ✓ Yes 2 No 1	Yes 2 No
ital ician: s certi: rector	BB	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2	26 Place of Death (Che ER/Outpatient 3 DOA Other Nu	eck only one)  irsing Home 5 Residence 6	Other: Scope
of Viring Physic After this	욘	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion (tending eath.	ţį	1 ✓ Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been side in by the funeral director, page 2 should t	ifi	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide determined (Specify)		or rown, state)	
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate thus after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t		29a Certifier 1 Certifying Physician: To the best of my knowled one) Wedical Examiner: On the basis of examination a			
To t with To t	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		(Month, Day, Year)
		KIL BUILTON	O.C.M.E.	September	6, 2012
7		30. Name and address of person who completed cause of death (Item	•	L	
7		Melissa Brassell, MD Assistant Medical Exami		more, MD 21223	
S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signat	are		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ 2012 September 11:50 PM Edith I. Packard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospital Prince George's Laure 1 . Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 577-36-3742 1 □ M 2x F 83 August 26, 1929 Virginia Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 🛣 No Prince George's Maryland Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20708 United States 9000 Briarcroft Lane death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married ☐ Yes 2 🙀 No f Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 Is and Mental Hygiene.
7 is marked other than "n Prince George's Elementary/Secondary (0-12) College (1-4 or 5+) 12 Culinary Assistant Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Hall Addison Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3340 Old Line Avenue, Laurel, Maryland 20724 Glenn Packard/Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State cemetery crematory or other place West Arundel 4 Donation 5 Other (Specify) 10, 2012 Odenton, Maryland Crematory ce Licens 21. Signature of Funeral S 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the shock, or heart the disease, or nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last g physician a Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE Physician/ 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 X No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 this certificate has autopsy performed? 2 🗌 No Yes 2 No 1 Yes 24 hours after death. e **Funeral Director**: After this certifica lately filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🔀 No ြုင 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

5√ State

Registrar
DHMH 17 Rev 06-2011

Scere

SEP 1 0 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saritha Gorantla, M.D., 7300 Van Dusen Road, Laurel, Maryland 20707

D70093

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PAUL DONNELL ROBERTSON SEPTEMBER 4, 2012 3:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia 7070 Winter Howard Social Security Numbe 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 54 223-90-9859 OManth, Day, Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-i sno ner must be notified at Director MID Howard Columbia 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 7070 Winter Rose 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) VA Hospital 12th grade 3 years nventory Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည E. Earline Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hose Path Columbia Mo 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 09/17/2012 4 Donation 5 Other (Specify) Garrison Forest Owings Mills, MD 22. Name and Address of Facility Vaugho 21. Signature of Funeral Service Licenses 8728 Liberty Road Kandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death END STAGE RENAL DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DIABETES MELLITUS TYPE II Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of, ESSENTIAL HYPERTENSION Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exected hours after death.

Puneral Director: After this certificate has been signed by the attending physician a leted filled in by the funeral director, page 2 should be detached for use as the burial-t Box 68760c IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚨 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 🗌 Yes 2 🗆 No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD# 32907 SEPTEMBER 7, 2012 M.D Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARLOS E. PALANT, M.D., VAMC, WASHINGTON, DC 50 IRVING STREET NW 20422 31. Date filed (Monts Per Year) 0 2012 State parke Registrar

		Plea	ase Type or Prin amend item State of Ma	it in E	Black li	ndelible In	k. Ens	sure All	Copie	s Ar	e Legible		
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Funeral		5. Social Security Number	6. Sex 7. Age		st birthday)	If Under 1 Year Months Days	If Under		B. Date of Bir (Month, Da	rth ay, Year)		rthplace (State	or Foreign
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ic; a Dan le (le Ray ire, Maryland 21215-0036 / The Maryland 21215-0036 / The Maryland of the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	eral D	10e. Street and Number 99:10 CERUIDO	. /			10f. Zip Code 2//3	3			10g. (	Citizen of What Co	ountry?	
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21215-0036 21215-0036 within 72 hours after giene. er than "natural", or the Medical Exami	ted by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	40		1 ☐ Yes 2 🗷 No		<i>r</i> :			Specify:	Wite	
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Pathics Baltimore, semit. Page 1 and Department of Hea mportant if them any lujury or other none.	1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of F											,	2////
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ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	23c. If yes, outcome o  1  Live Birth 2  4  Pregnant at	2 🗌 Fetal	Ideath 3	Ectopic pregnar Other (specify)	юу				23d. Date of de Month	elivery Day	Year
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. To the current Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but the strength of the funeral director.	Certificate:		gation not be 28e. Place of Injur			M 1	Yes 2				and Number or Ru	ural Route Nun	nber,
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To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2 Medical E	Examiner: On the basis of examiner: To the Nurse Practitioner: To the	amination	and/or inves	tigation, in my opin , death occurred at	the time, da	occurred at th	e time, date a	and place the caus	ce, and due to the se(s) and manner	cause(s) and mas stated.	nanner stated.
5 4 × 6 8		29b. Signature and litle of certifier	MD			29c. Licens	7633	4	ŀ	-	tember		20/2
- Male		30. Name and address of person	PUBOX 261	13.	Salis	bury m	D 2	1802					,
Star Registra		31. Date filed (Strip Day, Year)2	012 32. Registrar	's Signatu	ure Law	K)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 9:33 P M Patricia Elizabeth Stottlemyer August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Keymar 12443 Detour Rd. 8. Date of Birth (Month, Day, Yea Oct 11, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Year) 1935 1 🗆 M 2 🛛 F 76 Maryland Director 218-30-9186 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Keymar 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21757 U.S.A. 12443 Detour Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clothing factory 8 seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Barrick James Winebrenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keymar, MD 21757 Richard Stottlemyer/son 12443 Detour Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Important: It any injury or 9/1/2012 Oak Hill Cemetery Legore, MD 4 Donation 5 Other (Specify) Signature of Furieral Service Lice 22. Name and Address of Facility Hartzler Funeral Home, P.A. atharine ( 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Ouset and Death and Death Immediate Cause (Final mente Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 X No ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death?

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3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined npleted filled 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pyactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within 2

To the I only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Are Emmitsburg 10 Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 12-06706 Donald Steibe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 28705

		1- For State Registrar	Certific	cate of Death		Reg	g. No.	2010
Physici		Decedent's Name (First, Middle,Last)				Date of Death     Month	n Day Year	3. Time of Death
edical Exami	iner	Donald		Steibe		September	5, 2012	1140 hrs
		4a. Fecility Name (if not institution, give s 421 North Clinton Street	treet and number)	4b. City, Town, Baltimore	or Location of Dea	th	4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 216-66-3548	7. Age (In yrs. last b		ear If Under 24Hi ays Hours Mi		(MM/DD/YYYY) 9. Bir Foreig Co	
w any		Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Tow	n or Location				10d. Inside City Limits
·land	ğ	10 0	Build					1 X Yes 2 No
n the Maryland 3a or 28a-f show any otified at once.	Director	10e. Street and Number 421 N. Clinton	Street	10f. Zip Code 212			g. Citizen of What Cour	ıtry?
and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f shour traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No	13. Was Decedent of H	an, Mexican, Puert		White, etc.	can Indian, Black,
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36 thin 72 houre. than "natedical Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working li Housing In	fe. DO NOT use re	tired)		Baltimore
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Last) Charles A.	Steibe			e (First, Middle, Ma d Nowic	,	
MD 21 Id 2 should I ulth and Mer m 27 is man	To	19a. Informant's Name/Relationship (Type Carol A. Steibe		9b. Mailing Address (Str 123 S. Eas				
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mend Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State crema	e of Disposition (Name of catory or other place) Stanislaus	Cem 9-	10-12	20c. Location - City or Baltimore	e, Md.
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee		22. Name and Addre	ss of Facility J	oseph N.	. Zannino alto. Md.	Jr. F.H. 21224
Physician		23a. Part I. Enter the disease, or complica failure. List only one cause on each	ations that caused the death. Do r line.	not enter the mode of dyin	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. At	herosclerotic Cardiovasc e to (or as a consequence of):			BY PHENCY	YCLIDINE	Death
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ti .	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of):					
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Box 687 e death certific the attending j ed for use as ti	Physician/	past 12 months?	1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 5 Other (Specify)	Ectopic pregn	ancy	Month D	ay Year
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of V ing Phys After this uneral di	٩	1 ✓ Yes 2 No 27. Manner of Death	i inputent 2 Eroc	Outpatient 3 DOA  Time of Injury 28c. In	ury at Work?		esidence 6 🗹 Other: w injury occurred	Scene
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification	2 Accident Investigation 3 Suicide 6 X Could not be determined	28e. Place of Injury - At home, (Specify) FOUND AT	farm, street, factory, office	building, etc.	28f. Location (Str or Town, Sta BALT IMOR	teet and Number or Rur te) 421 CLINT	al Route Number, City 'ON ST
To the Hosp within 24 ho To the Func completely f	edical C	one) 2 Medical Examiner: Or	To the best of my knowledge, den the basis of examination and/or			d due to the cause(	s) and manner as state	d.
F.3 F. 8	₹	29b. Signature and title of certifier	d manner stated.	29c. Licer	se number		29d. Date signed (Mon	th, Day, Year)
111		Pote (1-1	Tolling		.M.E.		September 6, 201	12
15/1		30. Name and address of person who com Patricia Aronica-Pollak MD.	Assistant Medical Exar	miner 900 W. Balt	imore Street, E	Baltimore, MD	21223	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	what				

W				ype or Print in E						egible.	
$\sigma$			For State Registrar	State of Maryland		artment of I tificate of L		d Mental Hy	giene Reg. No. 2	012	28708
55	Physicia		1. Decedent's Name (First, Middle, Last)	RD.				2. Date of De		Year	3. Time of Death
	Medi Examir		CAROLE A. SPURRI  4a. Facility Name (if not institution, give stre			4b. City, Town, o	r Location of D			nty of Death	9:55 P. M
J			OAK CREST CARE CEN	TER		PARKVII				IMORE	
	Funeral Director		210-32-3070	7. Age (In yrs. la	st <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24   Hours N	Hrs. 8. Date of Bi Ain. (Month, D	th 935		place (State or Foreign try) LAND
a -	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Loc	ation					10d. Inside City Limits
2017	/anyla 8a-f s tified	Funeral Director	MD BALTIMOR	E F	PARKVI	LLE					1 ☐ Yes 2 🛣 No
$\frac{2}{2}$	n the N aor2 be no	<u>S</u>	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?
-	th with ms 23 must	ner	8800 WALTHER BLVD.		l sie ste	212			US		
1916	or ite		11. Marital Status 1 ☐ Never Married 2 【X Married	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo	1			(Specify Yes or No- uerto Rican, etc.)	14. F	Race - Amerio Black, White,	
2 }	urs aft ural",	ted t	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 XNo	Specify:		Spec	ify: WH <b>I</b> 1	Œ
	MILL 13-0030 within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give k	ent's Usual Occup ind of work done	ation during most of	working		f Business In IMORE	
1 8	vithin 72 within 72 rgiene. ner than '		Elementary/Seconday (0-12)	College (1-4 or 5+) + YEARS		NOT use retired) ACHER			1	HOOL	
35	filed Hard	To Be	17. Father's Name (First, Middle, Last) PAUL J. DENTZ					Name (First, Middle AM STROME		me)	
	<b>₹25</b>		19a. Informant's Name/Relationship (Type, M. EUGENE SPURRIER/					Rural Route Number			
1114	mit. Page 1 and partment of Heal portant: If item?		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		ace of Dispos metery, crem	sition (Name of eatory or other place	ce)	Date	20c. Locatio	n - City or To	own, State
= !	t. Page 1 tment of I trant: If it		4 Donation 5 Other (Specify)	MEG	RO CR	EMATORY,	INC. 9	/11/2012	CATON:	SVILLE	, MD
			21. Signature of Funeral Service Licensee	M00217	8	Name and Address	ss of Facility $oldsymbol{T}$	HE JOHNSO BLVD. TO	N FUNE WSON, 1	RAL HO	ME, P.A. 286
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one immediate Cause (Final	dons that caused the death. ause on each line.	Do not ente	r the mode of dyin	g, such as card	diac or respiratory a	rest,		Approximate Interval Between Onset and Death
9	Pnysician/ Medical		disease or condition resulting in death)	Due to (or as a conseque	1(a) / ence of):	KSA				-	
	Examiner	<u>.</u>	Sequentially list conditions.	Open was	nd LL	E					
w.	ed sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	PVA	inde of)t						
SEE.	executed an and ial-transit	Еха	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):						
3,	te be e nysicia	dical	d.								
A R	ertificat Jing ph	/Me	IF FEMALE:	If you guitagms of program		-					
	death c	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnance Other (specify)	y			Date of delive Month	ery Day Year
- 0	at the	/ Phy	Part II. Other significant conditions contri	buting to death but not resul	ting in the ur	derlying cause giv	ren in Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of death?
	uires th	d be	T20m, CAD			<del>-</del> -		_ 1 🗆	Yes 2 No	3 ☐ Prot	bably 4 🗆 Unknown
$\mathcal{U}$	lw requals bee	plet						24a. Was		). Were autor	psy findings available moletion of cause of
7	sician; The law I s certificate has k lirector, page 2 s	Com						eauto perfo 1 ☐ Yes	rmed? 2 No	death?	
<u>ء</u> ِ لح	ician; certific ector,	Be	25. Was case referred to medical examiner?  1  Yes No Hos	pital:		26. Pla	ace of Death (C		- 2		
$\gtrsim$ $\stackrel{>}{\sim}$	Phys ar this eral dii	e: To	27. Manner of Death		8b. Time of	3 DOA 28c. Injury	4 Nursin	g Home 5 Resident			)
$\Lambda$	ath. rr: Afte	ficat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work*	? Yes 2□No	254. 25001125			
SPURRIER Division of Vital Becords	al or Atte s after de il Directo	Certificate;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox		ber or Rural	Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after detarting Physician: The law requires that the To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	(Check Medical Examiner:	n: To the best of my knowled On the basis of examination a	and/or investig	ation, in my opinio	n, death occurr	ed at the time date a	nd place, and o	lue to the call	ise(s) and manner stated
-	Vithi To th		29b. Signature and title of certifier			29c. License	number		29d. Date sign		
			Michealle 5/1/a	W CLAP MISH		R1719	44		9/7/20	2/2	
5			30. Name and address of person who comp	oleted cause of death (Item 2	3a) (Type, Pr	int)	d. Pork	ville MA	2/23/4		
	Stat		SEP 1 0 2012	CLMP MSN 88	e do	الما	1 1 10/1				
14 / D	Registra HMH 17 Rev 7/20		ALI 1 0 2012	person p.	Mari						
Pr.	77 11GV 1/20										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P SINGO VANMOHAN 9.50 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary at Holy Cross **Burtonsville** Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months (Month, Day, Year) 220-13-5828 Director 1 X M 2 □ F May 15, 1919 Yrs India 93 Usual Residence of Deced 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Burtonsville Maryland Montgomery 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be n Funeral 4312 Sugar Pine Court 20866 United States items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or iter
injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Asian 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Farmer Crop Farming Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ganga Ram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sohan S. Saini/Son 14508 Friendlywood Road, Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date west Arundel Crematory September 8 2012 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licenses Donaldson Funeral Home 1411 Annapolis Road, O ne & Crematory, P.A. Odenton, Maryland 21113 Will Exponer M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 use as the l yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the ail 4 ☐ Pregnam 9 ☐ Unknown 9 Unknown Part IP-Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen EMENTIA 24b. Were autopsy findings available 24a. Was an e Hospital or Attending Physician: The law in 24 hours after death.
e Funeral Director: After this certificate has k prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation ☐ Accider☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I the only one 29b. Signature and title of certifie 29c. License number

State Registrar ASNEEM

Year)

10

2012

31. Date filed (Month, Day,

's Signature

30. Name and address of person who completed cause of death (Item 23a) (1) pe, Print)

28595

1528

204

29d. Date signed (Month, Day, Year)

WINGS MILLS MD 2117

12-06671 Andre William Scott

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 28708

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29b. Signature and title of certifier  29c. License number  O.C.M.E.  September 4, 2012  30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day Year)  32. Registrar Signature	certif	cian	past 12 months?	me of death	- =		Ectopic pr	regnancy		Month	Da	y Year
29b. Signature and title of certifier  29c. License number  O.C.M.E.  September 4, 2012  30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day Year)  32. Registrar Signature	Boy death he atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown		□ Otrie	ii (Opediy)			1			
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29b. Signature and title of certifier  29c. License number  O.C.M.E.  September 4, 2012  30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day Year)  32. Registrar Signature	After funers		1 Notural C (Month, Day, Yes	y 28I ar) 22	-	· 1		Subject sh		ury occurred	t	
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Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day Year) 32. Registrar Signatus			Care HADDON			O.C.	M.E.		Sep	otember 4	1, 201	2
Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day Year) 32. Registrar Signatus			30. Name and address of person who completed cause of de	ath (Item 23a	3)							
State 31. Date filed (Month, Day Year) 32. Registrar & Signature				aminer	900 W. Ba	altimore Str	eet, Baltim	ore, MD 2122	3			
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Director		213-86-8751	1XM 2 F		54	Yrs.				May '	1, 19	958	Country	ур- 1 ———
any any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or I	Locatio	n				_		100	d. Inside City Limits
<b>.</b>	7	Maryland Fro	ederick				F	rederi	.ck				1	X Yes 2 No
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ther de un', or		3 Widowed 4 X Div	vorced If Yes, Give Ye or Dates:	2 X No		1 🔲 \Upsilon	res 2 X	No specify	r:		S	Specify:	Whit	te
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36 in 72 l	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	ele	ctr	onics	techn	ician		eme	raenc	v ve	hicles
5-00 ed with ygiene other in	Som	17. Father's Name (First, Middle	, Last)		010				r's Name (Fi	rst, Middle,		_	name)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	Francis C. S							ildred					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once		19a. Informant's Name/Relations Francis C. Sapp			4	_	Address (St 9th S							Code)
and 2 lealth item 2 traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20b. Place of Disposition (Name of cemetery),										MD 21701 20c. Location - City or Town, State		
Baltimore, permit. Pages I an Department of Hea Important: If iter		St. Peter's Cemetery 9/10/2012 Libertyto									town	n, MD		
altin mit. P partme portar ury or		21 Signatur of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home												
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										762 Approximate Interval		
Physician Wedical		failure. List only one cause	on each line.										Ē	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		a consequence of		rosc	Terori	c car	diovas	sculai	DIS	ease	-	
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ted Insit	Exa	events resulting in death) Last Due to (or as a consequence of):												
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and opletely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transitions.	Physician/Medical	X UNPENDED	AMENDED	23a,pt.	II,27	, pe	r me,g	931 9	-11-12	sm				
68760, certificate be exe nding physician a	/Mec	IF FEMALE: 23b. Was decedent pregnant in t	h	outcome of preg	nancy							. Date of de		V
Ox 687  eath certific  attending	cian	past 12 months?	4 Preg	birth nant at time of de	2 Leath 5	=	I death or (Specify)	3Ectop	ic pregnancy		1	Month	Day	Year
O. Box at the death c by the atten ached for us	hysi	1 Yes 2 No 9 Un	9 OIN							Log Did			do do dos	cause of death?
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of Vital Records, g Physician: The law require ther this certificate has been si meral director, page 2 should t	Completed										ormed?	dea	ath?	pletion of cause of
tal Recian: The certificate		25. Was case referred to medica	al I				26.Pla	ace of Death	(Check only		2 No	, .	Yes	
Vita hysicial this cer	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outp	atient	3 DOA	Other <sub>4</sub>	Nursing H	lome 5	Resider	nce 6	Other: Sc	cene
Ing Ph	T:T	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred												
Division tal or Attendii rs after death.	catic		estigation	ce of Injury - At h	ome farm	street				f Location	(Street ar	nd Number	or Rural I	Route Number, City
Divi	ertifi	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify)  (Month, Day, Year)  1 Yes 2 No  1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									,			
Hospi 24 hou Funer		29a. Certifier 1 Certifying F	Physician: To the be											
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		aminer: On the basis and manner		nd/or inve	estigatio				e time, date				
	Σ	29b. Signature and title of certifi	ei					ense numbe C.M.E.				oate signed tember 7		
		30. Name and address of person	n who completed cal	use of death (Item	n 23a)									
(3)		Donna M. Vincenti, M		Medical Exar		900 V	V. Baltimo	ore Street	t, Baltimoi	re, MD 2	1223			
S	tate	31. Date filed (Month, Day, Year,	) 32.F	tegistrar's Signat	иге	,	, ,							

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 31, 2012<sup>ear</sup> Louise Driver Silverman 9:50 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's 3148 Gracefield Road Apt. 404 CLSilver Spring Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 1 M 2 F Country) Alabama 421-26-6785 April Pay3 (April 1993) 1924 88 **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hyglene. and the filem \$23a or 28a-f sho and the filem \$27 is marked other than "natural", or items \$23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Silver Spring MD 1 Yes 2 X No 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3148 Gracefield Road Apt. 404 CL12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Idell Mary Cobb Clyde Driver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Foss - Daughter 3903 Fox Valley Dr. Rockville, MD Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 9 - 5 - 12Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur f Funeral Service Licen 22. Name and Address of Facility Metropolitan Funeral Service Vine St. Alexandria, VA 22310 5517 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate immediate Cause (Final 5 nset and Peath Physician/ Seizure Disorder disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s performed' funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 K Residence 6 Other (Specify) မှ 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 🔁 Natural injury 5 Pending Accident Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

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31. Date filed (Month, Day, Year) State 0 2012 Registrar

29b. Signature and titl

Mark Parkhurst, MD

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Parkhurst, MD 3110 Gracefield Rd. Silver Spring, MD 20904

29c. License numbe

D24093

29d. Date signed (Month, Day, Year) 9-5-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LOU SPLINTER 2012 MARY 4:59 pm September 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 427 Upshire Circle Gaithersburg 5. Social Security Number 8. Date of Birth (Month, Day, Yea Jan 21, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Hours 394-40-7305 69 Wisconsin Yrs 1943 Jan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Gaithersburg 1 🛚 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 427 Upshire Circle 20878 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Public High School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ann C. Nesser Arthur W. Splinter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 W. Grant Place Unit B 60614 (Brother) Chicago, IL Ronald P. Splinter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9-14-12 Sheboygan, WI 4 Donation 5 Other (Specify) Calvary Cemetery e of Funeral Service Licenses Metropolitan Funeral Service 22. Name and Address of Facility Alexandria, VA 22310 5517 Vine St. part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pulmonary Embolism disease or condition resulting in death)

Ph\_sician/ Medical **Examiner** 

Physician/

Medical

10a. State

MD

Director

Funeral

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Examiner

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**Director** 

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Department of Health ar Important: If item 27 is any injury or other trau

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Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit attending physician the as signed by the a page 2 funeral director, Be P Certificate: filled in by the

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	if any, Isading to infinediate cause. Enter Underlying Cause (Disease or iinjury	b. — Due to for as a sonseque	snee or):						
	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
y sicially inc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  Month							
2	Part II. Other significant conditions con Multiple Sclere		23e. Did tobacco use contribute to the cause of death?						
2	- Hallipic Beleix	1 L Yes	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
					24a. Was an autopsy performed?	prior to col death?	osy findings available mpletion of cause of 2  No		
3	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)				
	1 Yes 2 🔼 No	lospital: 1  Inpatient 2  E	ER/Outpatient 3 ☐ t	OOA Other: 4 \( \sum \) Nursing H	ome 5X Residence	6 Other (Specify,	)		
il care.	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred			
5	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		ry, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			

1🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantice or T. the Court of my incoming death occurred at the time, date and place, and due to the cause(s) and manner stated.

D005120

29c. License number

City or Town, State)

29d. Date signed (Month, Day, Year)

9 - 6 - 12

Registrar

Division of Vital Records, P.O. Box 68760

State

To the I within 2

Medical

29a. Certifier (Check

enc sinc 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Emmer 6316 Democracy Blvd. Bethesda, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 Month Physician/ Year ppember 2012 Spencer Jennings Leroy
Facility Name (if not bestitution, give street and number) Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center

6. Sex 7. Age (In arroll Nestminste If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-28-6739 1 🛂 M 2 🗆 F 78 Director 8-24-1934 MD 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at Director Westminster Carroll MD 1 Tyes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21157 Completed by Funeral 1208 Random Ridge Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tool and Mental Hygiene. Inspector 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Naomi G. Caple Irving S. Spencer permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Ensor-daughter 1203 Random Ridge Rd., Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Evergreen Memorial 9/12/12 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral & Cremation 21. Signature of Funeral Service Licensee 7 Main St., Westminster, MD 254 E. Nomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to for sea consequence of): resulting in death) Medical <sup>'</sup>Examiner Ohitmet Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Dopnesijas, Diabetes Type 2, gout Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 NO Parapleza, Periphend artical disease, Benga Prostatic 24a. Was an autopsy performed? Yes 2 N tension Chroniz 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at ieral Director: After in filled in by the funer Natural Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Die Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 69086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

CHINTU SHARMA

31. Date filed (Month, Day, Year)

Mr

32. Registrar's Signature

Carroll Hospital Center

Westminylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SEPTEMBER D 2012 11:01 P M ELLIOTT SEARS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death ST. MARY'S ST. MARY'S HOSPITAL LEONARDTOWN Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Hours 1071471925 MD 86 Director 216-16-9269 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 🗆 Yes 2 😾 No CROFTON MD ANNE ARUNDEL 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 1852 WEST QUEENS COURT 21114 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify "natural" Completed 3 😾 Widowed 4 🗆 Divorced WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 TECHNICAL ENGINEER U.S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ **SEARS ESTHER** FEINSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21557 CENTER POINT CIRCLE, ASHBURN, VA ROBERT SEARS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PK. : 09/07/2012 REISTERSTOWN, MD of Funeral Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ minutes disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burners. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 DOA Manner of Death Medical Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

ABATUNDE ROGBEM

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

(Check only one) 29b. Signature and title

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

PO Box 524 Leonardtown, MO 2005C

29c. License number 068989

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Erin Leann Walker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2012- 28714 Reg. No Registrar Decedent's Name (First, Middle Last) Physician/ 2 Date of Death 3 Time of Death **Medical Examiner** 0830 hrs September 4, 2012 Erin Leann Walker 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8622 Cobblefield Drive Apt. 3D Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 28 April 12, 198 1 M 2 X F 174-72-0892 Yrs Japan Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be optified at once. MD Columbia 1 Yes 2 K No Howard IMOCE, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
aot: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be optified at once. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8622 Cobblefield Dr; 21045 Apt 3D USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. 1 X Yes 2 No 2007 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: Caucasian Present る 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cryptologic Linquist; Korean U.S. Marine Corps 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Stephen Wagner Mary Jones 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Wagner- Father 6143 Spring Knoll Dr. Harrisburg, VA 17111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Department of H. Important: If it in injury or other t crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Atlantic Crematory 9/10/2012 GLen Burnie, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Thibadeau Mortuary Service, P.A. Park Avenue, Gaithersburg, MD 20877 James J. Thibadeau, per DVR 7 Park Avenue, Gaithersburg, MD 20 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disable) or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ician/Medical AMENDED, per FD G931, 9/20/12 TRT UNPENDED certificate has been signed by the attending physician ector, page 2 should be detached for use as the bunal Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 ✔ No 1 Yes 2 No Hospital or Atteodiog Physiciao: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject hanged Natural FOUND: Director: d in by the f Pendina 1 Yes 2 No Sep 4, 2012 0820 hrs filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8622 Cobblefield Drive Apt. 3D, Columbia, MD within 24 hours a To the Fuoeral I determined (Specify) Multi-Family Apt 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 5, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD

DHMH 17 Rev 1/2001 **OCME 2006** 

State. Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	1arylan					ental Hy	giene			
	1 - State Registrar Certificate of Death							Reg. No. 2012 2871						
	1. Decedent's Name (First, Middle, Last)  Physician/						2. Date of Death Month					Day Year		
Medical Queen Esther Washington						t Income			on of Dooth					:30 A <sup>M</sup>
4a. Facility Name (if not institution, g				,	,			4b. City, Town, or Location of Death Silver Spring			4c. County of Death  Montgomery			
	Funeral		5. Social Security Number	6. Sex 7. Ac	ge (In yrs. Ia	st birthday)	If Under 1 Ye	ear If Und	der 24 Hrs.	8. Date of Birth			9. Birthplace (State or Foreign	
3.	Director		578-44-2609	1 □ M 2 🛛 F		97 <sup>Yrs.</sup>	Months Da	ys Hours	rs Min.	Month, Da 8/03/	1916	No	rth C	arolina
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		چَ	MD Montgomery Silver S					10f. Zip Code				zen of What C		
		Funeral	10700 Kinloch Road 20903 U								USA			
		Œ	11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Vas Decedent of Yes, specify C	of Hispanic (	Origin? (Spec	cify Yes or No-		14. Race - Am		an,
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Maryland			19a. Informant's Name/Relation			l .	g Address (Stre							
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Baltimore,	t. Page tment of tant: If tjury or		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	1 3 Removal from State	e ce	emetery, crem	atory or other	place)						116
ij			21. Signature of Funeral Service		Llne	COIN C	emetery Name and Ad	dress of Fac	: 9/0//	/2012	Sui	tland.	MD	
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Æ	Physician/		Immediate Cause (Final disease or condition	described.		culer	Disease	2						and Death
-	Medical Examiner		resulting in death)	Due to (or as			DIBCUDE							
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	Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury  Hyppertns ion											
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Box	requires that the death been signed by the att should be detached fo	Physician/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 🔲 Pregnant a 9 🔲 Unknown	at time of de	eath 5	Other (specify	)				Month	Day	Year
P.O.				ons contributing to death but not resulting in the underlying cause given in P			in Part I. 23e. Did tobacco			use contribute to the cause of death?				
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Zi.	Physici this cer al direc	70 E	examiner? 1  Yes 2  No	Hospital:	ient 2 🗆 E	R/Outpatient	3 🗆 DOA	Other: 4 🗆	Nursing Hon	ne 5 🎇 Resid	ence 6	Other (Spec	ify)	
10	ing Pl	ate:	27. Manner of Death  1 X Natural 5 Pendi	28a. Date of inju ing (Month, Da	ury 2 ay, Year) 2	28b. Time of injury	W	njury at vork?	_	3d. Describe h	ow injury	occurred		
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Νį	I or Atten after deat Director: I in by the		4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)							City or Tow	(Street and Number or Rural Route Number, own, State)			
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	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Med	(Check 2 ☐ Medical	Examiner: On the basis of e	examination :	and/or investi ബായനർട്ടറ, മ	gation, in my or	oinion, death	occurred at t	he time, date a and sure to the	nd place, a couse(8)	and due to the and manner as	cause(s) ar	nd manner stated.
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_			30. Name and address of person			, , , , ,	,	- 000	) II	- or-111	, 1.47	20702		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 50 Hember 2ay 2138 M William Yurick Medical 4a. Facility Name (if not institution, give street and numb City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Makyland Greneral 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 ፟፟፟ M 2 □ F Months Hours Min. Dec 12, Year 1923 88 Director 177-16-9939 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 21223 USA 1217 W. Fayette St. Was Decedent Ever in U.S. Armed Forces? **unk** 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk19a. Informant's Name/Relationship (Type, Print) Shirley Ditommasso - friend 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Rona La 655 W. Baltimore St; Baltimore, MD 21201 23a. Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ umonar disease or condition Medical resulting in death) Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No has been signed by the are 2 should be detached Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò brillation Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 2 🗌 No Yes Division of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 ER/Outpatient 3 DOA |은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

V1/18m

who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anderson 9:40 A.M. lea Bonnie August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Spring ilver Cross 5 Montgomer Hospital Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 214-52-1188 Director 1 □ M 2 🕱 F 6 Maryland 28a-f shov or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Silver Mont 1 Yes 2 No Mary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11.5.A. Terrace 3003 20904 per +on 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Black Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Mechanica ine 6th grade Worker e 1 and 2 should be filed wit of Health and Mental Hygie If Item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anderson permit. Page 1 and 2 should be Department of Health and Men-Important: If Item 27 is marke any injury or other traumatic v Rober t Son 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anderson-3003 Katrina Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Criffield, MD 4 Donation 5 Other (Specify) opewell U.M.C. Cemetery 21. Signature of Funeral Service Licensee War Anthony 30639 Princess Anne mD, 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner eumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Malianant Due to (or as a consequence of): resulting in death) Last 1etastatic Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 Yes 2 No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work≀ 1 ☐ Yes 2 ☐ No Investigation 3 🔲 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) Alagar Forest Glan Rd Silver Spring MD21910 1500 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

AUG 2 2 2012

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Year Day Month 8 **Physician** 19 9:00 A M Helen Louise Alger /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3117 Addition Ave Knoxville Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 9/6/1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗸 □ F 86 Yrs. MD. 215-20-9490 Director Usual Residence of Decedent tha Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-1 show other traumatic event, the Medical Exemper must be notified at 1 Yes 2 No Director MD. Frederick Knoxville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ŏ 3117 Addition Ave. or Itema 23a 21758 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. Orden: If item 27 is marked other than "natural; or ite injury or other traumatic event, it is Medical Exert in Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 3 ☐Widowed 4 ☑ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Board of Fouration 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lester Lee Lloyd Arrah Wilt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane Alger, Daughter 3117 Addition Ave. Knoxville MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or Park Heights Cemetery 8/22/2012 Brunswick MD. 21. Signature of Funeral Service License 22. Name and Address of Facility garet John T Williams Funeral Home, Brunswick MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MANY Physician YORS CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Examiner MANY YEARS ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signad by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA (his ( 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AUG. 20, 2012 00016675 ares derson who completely cause of death (Item 23a) (Type, Print)

ALLOMER, 515 WEST 30. Name and address of MD 19 BRUNSWICK, 57. WAYNO WEST 32. Registrar's Signature 31. Date liled (Month, Day, Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1750AMM Roste Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death CHARLES GENESIS LA PLATA CENTER PLATA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2🛣 F Months Days Hours Min. JUNE IO ),1921 Director MARYLAND 219-82-4900 91 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 TNo MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10100 LYLES PLACE 20603 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Yes 2 🖾 No If Yes, Give à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ုဝ NETTIE PADGET CHARLES PICKERALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10100 LYLES PLACE WALDORF, MD 20603 CHARLES R. ADAMS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 😾 Burial 2 🗌 Cremation 3 🗍 Removal from State 20c. Location - City or Town, State Date 8/30/2012 CHELTENHAM, MD Donation 5 Other (Specify) ΜD VETS.CEMETERY 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/  $\omega$ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** lure to Sequentially list conditions, if dr.y, leading to immediate cause. Enter Underlying Examir and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Box 68760 as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed 2 No Yes 1 Tes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 2XNo 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pendina nours after death.

neral Director: Af
iffled in by the fu 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the F 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHOL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 12:55 M Month Physician/ 2012 George McPherson Bowling, Jr. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 15040 Burnt Store Road Hughesville Social Security Number 7. Age (In vrs. last birthday) ear If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) Director 214-30-0846 1 🕅 M 2 🗆 F 79 Yrs 09/23/1932 Washington, DC Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Charles Hughesville 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 15040 Burnt Store Road 20637 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner rmed Forces? Black, White, etc. ō 1 Never Married 2 X Married by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner / Operator Retail Fuel Station other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည Mary Catherine Bowling George McPherson Bowling, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st t of Health a : If item 27 is Dorothy Mae Bowling / Wife 15040 Burnt Store Rd., Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. Mary S Catholic Church Cemetery 1 X Burial 2 Cremation 3 Removal from State injury or Department In Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 08/27/2012 Bryantown, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 Part 1. Eight the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 30195 Three Notch Rd., Charlotte Hall, MD 20622 Immediate Cause (Final Onset and Death Ph ician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical that the death certificate be P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year g Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performe has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DCA this 28a. Date of injury (Month, Day, Year) Manner of Deat 28b. Time of I Director: After the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year,

10+1 dle

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

2-06374		Please Type or Print in Black Indelible	e In	k. Ensur	e All Co	pies	Are Legi	ble.		
David Russ Bro	own	State of Maryland / Department			d Mental	Нус	jiene	7	חי	2 28721
_		1- For State Certificate	of i	Death			Reg.		. •	
Physic Medical Exam							Date of Death Month E August 24, 2	ay Y 2012	ear	3. Time of Death 0015 hrs
		Aa. Facility Name (if not institution, give street and number)     18936 Flat Iron Road	-	o. City, Town, or Valley Lee	Location of D	eath		4c. Count		ith
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		If Under 1 Year Months Day		Min.			Fore	irthplace (State or ign
		525-19-9940	Yrs.				10/ 10/	1966		country) Florida
w any		10a. State 10b. County 10c. City, Town or Lo	ocatio	n						10d. Inside City Limits
Maryland 28a-f shuw d at once.	호	Maryland St. Mary's Valley 10e. Street and Number								1 Yes 2 No
i with the Maryland ms 23a or 28a-f shu be notified at once.	Director	18936 Flat Iron Road		10f. Zip Code 20692				Citizen of V		
with the 18 23a e noti	E		Was	Decedent of His	spanic Origin?	(Spec		nited		erican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes	s, specify Cubar	n, Mexican, Pu	erto Rio	cán, etc.)		ite, etc.	
s after rral",	<u>۾</u>	or Dates:		res 2 No	, ,			Specify		ite
2 hours after "natural"	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		Usual Occupa st of working life				6b, Kind of E	usiness	s/Industry
)036 within 72 iene. or than	Completed	12 Offi	ce	Manager	2			Automo	tiv	e
15-0 filed w I Hygic of others						,	irst, Middle, Mai	den Surnam	e)	
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than "natic event, the Medical.	o Be	Thomas Brown  19a. Informant's Name/Relationship (Type, Print )  19b. Ma	iling A	Address (Stree	Barbar et and Number		Fiore	r. City or To	wn. Stat	e Zin Code)
MD 32 sho th and 27 is	-									ryland 20650
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after no of Fleath and Mental Hygiers, it. If then 27 is marked ather than "natural", ather traumatic event, the Medical Examines.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State crematory or	positio	on (Name of ce						r Town, State
드리의를날		4 Donation 5 Other Specify: Brinsfie	1d-	-Echols	08	/31	/2012 C	harlot	te	Hall, Maryland
Balti permit. Departri Importa		The state of the s		me and Address	ע		sfield			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	ZZ9 er the	mode of dying,	such as cardia	KOA ac or re	d。Leon spiratory arrest,	ardtov shock, or h	m. eart	Maryland Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a, Intra-oral Gunshot Wound								Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):								
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
ecuted and - transit	al E	d.								
ă E E	edic	UNPENDED								
876 tificate ng phy as the t	In/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal	death 3	Ectopic pre	gnancy		23d. Date o		ry Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		r (Specify)						
that the dended by the detached f		Part II. Other significant conditions contributing to death but not resulting in the	ne und	derlying cause g	iven in Part I.		23e. Did toba	cco use cont	ribute to	the cause of death?
of Vital Records, P.O ag Physician: The law requires that the tribute this certificate has been signed by meral director, page 2 should be detac	d by					_ 1	1 Yes	2 🗸 No 3	Pro	bably 4 Unknown
cords, law requir has been s	plete					- "	24a. Was an autopsy			utopsy findings available completion of cause of
Rec The la icate h	Completed						performe		death? I ✔ Y	es 2 No
ital Redictant	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	4 6		of Death (Che		one) ome 5 Re		4	
ing Phys After thi Tuneral di	년 1	27. Manner of Death 28a, Date of Injury 28b, Time of State of State of Injury 28b, Time of State of Stat			y at Work?	280	d. Describe how	injury occur		er: Scene
ion tendin eath. tor: A the fur	ation	1 Natural 5 Pending Aug 24, 2012 0005 hrs		1 \ Y	es 2 🗸 No	Su	bject shot s	elf		
Division lal or Attendi safter death. lal Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st		factory, office b	uilding, etc.		or Town, State	)		ural Route Number, City
Di lospital l hours a uncral I ly filled	S	4 Homicide determined (Specify) Single Family Home				-1	36 Flat Iron R	oad, Valle	_	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one)  2 Medical Examiner: On the best of my knowledge, death oc one)  and manner stated.								
8 4 8 4	₽	29b. Signature and title of certifier		29c. License	number	_	29	d. Date sign	ned (Mo	onth, Day, Year)
		mu-		O.C.M	И.E.		A	ugust 24	, 2012	
1/2		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltim	Orc.	Street Balti	more MD	2122	3			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	tate	31. Date filed (Month, Day Year) Registrar's Signature			- NID	Z 1 Z Z .				
Regist	-	AUG 2 8 2012 Sener B. Jan	Ka							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month William Daniel Brown 9:47 PM Medical 2012 lugust 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall Mary's 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days (Month, Day, Year) 08/02/1929 83 Director 492-30-4287 Michigan Usual Residence of Decedent 28a-f shov 10b. County 10a. State with the Maryland Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland St. Mary's Mechanicsville ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 26281 Abigail Lane 20659 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces:
1 X Yes 2 If Yes, Give 1 Never Married 2 Married ò ģ 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement 12 Capitol Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe Harold Glenn Brown Florence Evelyn Voorhies Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Carol Connelly/Daughter-in-law26283 Abigail Lane, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-EcholsCrem: 8/28/2012 Charlotte Hall, MD M00817 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Signature of Funeral Service Licenses 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o. as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and set filled in by the Intered inector, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown g 🗌 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 10Gen 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ♠No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature au signed (Month, Day, Year) 0 0

DHMH 17 Rev 7/2009

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State Registrar 9449

eHall

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hy

		1 - State Registrar	partment of Health and M ertificate of Death	riental Hygler Reg. i	No.2012 28723
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last)  Rosa Lydia Bigsby		2. Date of Death Worth 16/2	3. Time of Death 11:00 p <sub>M</sub>
Exam		4a. Facility Name (If not institution, give street and number) Calvert-Burnett Hospice House	4b. City, Town, or Location of Death Prince Frederi		4c. County of Death Calvert
Funer		5. Social Security Number  439–50–9989  6. Sex  1 □ M 2 🖾 F  80 Yrs	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea 11/05/193	
yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
the Mar 28a-f st	ector	MD Calvert Dunki			1 □Yes 2 ▼ No
ath with 23a or wet be	Funeral Director	9900 McIntosh Drive	10f. Zip Code 20754	10g. (	Citizen of What Country? U.S.A
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinat mat be a cilified at	à	3 ☐ Widowed 4 ☐ Divorced If Yes, Give	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 XYes 2 □ No Specify: Puer		14. Race - American Indian, Black, White, etc. Specify: Hispanic
215-( 215-h 21 min 72 h 21 min matu Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) (Gillero (4.4 o. 5.)	cedent's Usual Occupation ve kind of work done during most of worki b. DO NOT use retired)	ing 16b.	Kind of Business/Industry
d 2121 filed within Hygiene. other than "nent, the Me	Com	Elementary/Secondary (0-12)  College (1-4or 5+)  Ow  17. Father's Name (First, Middle, Last)	ner	e (First, Middle, Maide	Day Care
Maryland d 2 should be file th and Mental Hy 77 is marked othe traumatic event,	To Be	Bernardo Olmedo	Cruz A		en Surname)
Nd 2 July 27 is r tra			ulling Address (Street and Number or Rura Empire Court, Dunk		
Baltimore, bermit. Pages 1 ar Department of Her Important: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Discernetery, compared to the compa	position (Name of Dematory or other place)	Date 20c.	Location - City or Town, State
Baltimo permit. Page: Department o Important: If any injury or	<u> </u>	21. Signature of Funeral Service Licens	ans Cemetery 08/23	e Funeral	eltenham, MD Home Calvert. P.A.
	ol .	23a Part 1 Enter the disease or complications that caused the death. Do not	6200 <del>Jenn</del> lier Lane,	, Owings,	MD 20736 Approximate
Physiciar /Medica	_	Immediate Cause (Final	on PNPUNC	ma	Interval Between Onset and Death
Examine	1	Due to (or as a \ \nsequence of):	XAScular a	ccide	nt
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events .	Tan Section	127	disease
<b>DOT OU,</b> tificate be executed by physician and as the burial-transit		resulting in death) Last  Due to (or is a consequence of):	11.0.1(= 11.5)	conce	a lace a
ertificate	Medical	IF FEMALE:			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 \subseteq Live birth 2 \subseteq Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ires that signed to	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
aw requires t as been signe	Completed	multi-infact do men	ha	1 ∐ Yes 2	2 No 3 Probably 4 NInknown  24b. Were autopsy findings available
n: The l				autopsy performed? 1 ☐ Yes 2 🗷 N	prior to completion of cause of death?
Physicia Physicia this certi	To Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death ont 3 DOA Other: 4 Nursing Hom	(Check only one) me 5 ☐ Residence	6 Other (Specify)
nding P tth. :: After t e funera	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) Injury	of 28c, Injury at 2	28d. Describe how inju	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
e Hospit 24 hour e Funera letely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal of the companient of the pasts of examination and/or and manner stated.	tth occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause( ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type			1 Hug 2012
JRW 6	ate		Sares	Prince	Fred, UD
Regist		AUG 17 2012 Denua B.	pare		

DHMH 17 Rev 1/2001

			1 - State of Marylar State of Marylar Registrar WCHD/TF 8/30/12 PER FH	nd / Depa <i>Cer</i>	artment of He tificate of De	ealth and M eath		giene Reg. No. 20	112 28724
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Medic	al	The Ima Nadine Boward  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	agation of Dooth	August	27, 20	
	Examin	er	18527 Kent Ave.		Hagerst				nington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir	th	Birthplace (State or Foreign Country)
	Director		219-20-1769 Usual Residence of Decedent 1 □ M 2 🖾 F 100	Yrs.			Aug. 1	8 <sup>Year)</sup> 1912 9,1920	Maryland
	/land f shov ed at	tor	10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
	e Mary r 28a-	Director	MD Washington Ha	agersto					1 ☐ Yes 2 🖾 No
	with th		18527 Kent Ave.		10f. Zip Code 21740			10g. Citizen of V	vnat Gountry?
	death vitems	Funeral	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No-	14. Race	e - American Indian,
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2 XNo		Yes 2 X No		ilouri, etc./	Specify:	k, White, etc.  White
9-0	hours nature lical E	Completed	15. Decedent's Education		ent's Usual Occupati			16b. Kind of Bu	usiness/Industry
21215-0036	hin 72 ne. than " ie Mec	omo	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	life. DO	ind of work done dur O NOT use retired)	nng most of workli	n <i>g</i>	<b>.</b> .	
d 2	filed wit al Hygie d other	Be C	7th 17. Father's Name (First, Middle, Last)	Lathe	Operator	8. Mother's Name	(First Middle		ent Mfgr.
/lan	should be file h and Mental I 7 is marked o raumatic eve	으	Benjamin Samuel Gouker			Laura 0			,
lan	should and h is me		19a. Informant's Name/Relationship (Type, Print)	1	g Address (Street an				tate, Zip Code)
e,	and 2 s Health tem 27		Kenneth Toms / Grandson  20a. Method of Disposition 20b. F		Kent Ave		town, M		City or Town, State
mor	Page 1 ment of ant: If it ury or o		1 XBurial 2 Cremation 3 Removal from State	cemetery, crem	natory or other place)  Cemetery	i	/2012		town, MD
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22.	. Name and Address	of Facility Ger	ald N.	Minnich	Funeral Home
ш	20 E 20 20		C/37-24 F		05 N. Pot				MD 21740
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to min a consequence of the conditions, b.	Te d	Henri		r respiratory an	rest,	Approximate Injernal Between Ginservano Defati
	certificate be executed anding physician and use as the burial-transit	l Examiner	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the con						
200	ate be	edical	d						
O. Box 687	death certifi ne attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  1 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fete 4 ☐ Pregnant at time of 0 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day Year
σ,	The law requires that the derare has been signed by the a page 2 should be detached	ted by P	Part II. Other significant conditions contributing to death but not res	sulting in the ur	nderlying cause giver	n in Part I.	23e. Did to		ibute to the cause of death?  3  Probably 4 Unknown
Division of Vital Records,	The law ate has page 2	Completed by					1 L Yes	osy p	Vere autopsy findings available prior to completion of cause of leath?  Yes 2 No
/ita	or Attending Physician: after death.  Director: After this certification by the funeral director.	To Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital: 1  Inpatient 2	ER/Outpatien	Other	e of Death (Check	17	dence 6 ☐ Othe	or (Specific)
of	ng Phy ter this ineral o		27. Manner of Death  28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a		7	ow injury occurre	
ion	tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investigation		M 1 □ Y€	es 2 🗆 No			
Divis	tal or At rs after o al Direct led in by		4 Homicide determined 28e. Place of Injury - At he building, etc. (Specify		et, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know the decidence of the basis of examination only one)  2 Medical Examiner: On the basis of examination of the basis of the basis of examination of the basis of examination of the basis of th	n and/or investi	igation, in my opinion,	death occurred at	the time, date a	nd place, and due	to the cause(s) and manner stated.
D	To tl withi To th		29b. Signature and title of certifier		29c. Liounicein	43550		29d. Date signed	(Month Day, Year)
JU	N-8		30. Name appraddress of person who completed cause of death (Item	UD	rint) Sim IT	USBUR	IL, M	0/2	1783
	Stat Registra		31. Date filed (Month, Der Year) 2017 32. Begistrar's Signa	ture.	and I				
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		1- For State Registrar		Cer	tificate o	f Death			Reg. N	<u>د</u> د اه.		
Physic		Decedent's Name (First, Midd	le,Last)					2. Dat	e of Death			3. Time of Death
Medical Exam	ine	WIDEM VI	CHARD B.	ARKLEY				Aug	gust 17, 20	)12 <sup>rear</sup>		0401 hrs
7		4a. Facility Name (if not institution		mber)		4b. City, Town, o	or Location	of Death		4c. County of		
		Prince Georges Hosp	ital Center			Cheverly				Prince Ge	orge'	s
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ist birthday)	If Under 1 Ye			ate of Birth(M			place (State or
Director	ľ	744-96-9940	1[X]M 2 F		Yrs	Months Da	ys Hours	s Min. 06	5-15-20	012	Foreign Cour	ntry) MD
		Usual Residence of Decedent										
Any		10a. State 10b. County		10c. City,	Town or Local	ion						10d. Inside City Limits
nd ibow	<u>_</u>	MD PRINC	E GEORGE'S	S BOW	TE.							1 XYes 2 No
Maryland 28a-f show i at once.	양	10e. Street and Number				10f. Zip Code			10a. (	Citizen of Wha	t Count	rv?
ith the Maryland 23a nr 28a-f sho notified at once.	Director	12215 KINGS A	RROW STREI	ጥ		207	771		"	J.S.A.		,
rith ti 123a 100ti		11. Marital Status		edent Ever in U.S	142 144	s Decedent of H		-1-0 / 017 . 24				
ath v items	Funeral	1 X Never Married 2 M		rces?		es, specify Cuba				14. Race - White,		an Indian, Black,
er de	[교	3 Widowed 4 Div	1 Yes orced If Yes, Give Yea	2 X No		Yes 2X N					DT A	OIZ
ırs af ural	<u> </u>	15. Decedent's Education (Spe	or Dates:		16a Deceder	t's Usual Occup			no 116k	Specify:	BLA	
2 hou "nat	tec	Elementary/Secondary (0-12)	College (1			ost of working lif			I I I I I	. Killa of Busi	11622/1116	dustry
36 hin 7 e. than	ompleted	0	00.0000(.	,	NO	VF.				NONE		
5-00 led wit fygien other the Me	Į,	17. Father's Name (First, Middle,	Last)		1102		18 Mother	r's Name (First,	Middle Maide			
21215-0036 Id be filed within 72 Aental Hygiene. narked other than '	Be C	RICHARD R. BA	•					INA McDO		en oumanie)		
21215-00; 21215-00; ould be filed with. Mental Hygiene, marked other tl	To E	19a. Informant's Name/Relations			19b. Mailine	Address (Stre				City or Town	State	Zin Codo)
and 2 shou fealth and N		RICHARD R. BA		HER		KINGS A						
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygeric Mental Hygers I will the 27 is marked other than "natural", ur items 23a nr 28a-f shown rither traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition				ition (Name of c		Date		c. Location - C		
Ore ges 1 t of 1		1 X Burial 2 Cremation	3 Removal fro	om State CI	ematory or otl	ner place)					•	·
timen trant	l li	4 Donation 5 Other Sp		WAS	H. NAT	. CEMETE	ERY	08-25-1	.2 St	JITLAND	, M	D
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or nither traum		2 Signature of Funeral Service		01206	22. N	ame and Addres	ss of Facility	PINCKN	IEY-SPA	NGLER	F. ]	Н.
	- 1	DEIN		01286	524	4 - 8TH	STREE	ET, N. E	. WASH	I., DC	200	
Physician /Medical		23a. Part I. Enter the disease or failure. List only one cause	complications that ca on each line.	used the death.	Do not enter ti	ne mode of dying	), such as c	ardiac or respira	atory arrest, s	shock, or heart		Approximate Interval Between Onset and
Examiner	: 1	Immediate Cause (Final disease		Unexpla	ined D	eath in	Infar	cv (SIII	)T)			Death
		or condition resulting in death)	Due to (or as a	consequence of)				, (				
	6	Sequentially list conditions, if any, leading to immediate	b. Due to /or as a	consequence of)			_					
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	Examiner	events resulting in death) Last	NAME OF TAXABLE PARTY.	consequence of)	:							
38760, rtificate be executed ing physician and as the burial - transit												
760, cate be ex physician the burial	n/Medical	X UNPENDED	AMENDED 2	3a,27,28	Ba-f,pe	r me,g9	32 10	-9-12 s	m		l	
76( icate iphys	/We	IF FEMALE: 23b. Was decedent pregnant in th		utcome of pregna					2	23d. Date of de		
Box 687 ne death certific the attending I		past 12 months?	I , TIVE D	rth ant at time of			Ectopic	pregnancy	5.0	Month	Da	y Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unk	nown 9 Pregna		5 Ott	ner (Specify)						
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Acords, P.O. Box 6 he law requires that the death cer are has been signed by the attendi age 2 should be detached for use.	ğ	_				indonying oddoo	givoninia					bly 4 Unknown
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of Vital Records, ag Physician: The law requirements this certificate has been so neral director, page 2 should the stream of th	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	patient 2 🗸 E	R/Outpatient	3 DOA	Other <sub>4</sub>	Nursing Home	5 Resid	dence 6	Other:	
		27. Manner of Death	28a. Date o	of Injury 2 Day,Year)	28b. Time of Ir	njury 28c. Inju	ury at Work	? 28d. De	escribe how in	njury occurred		
	흴	1 Natural 5 X renu	mg c. o		610.10	_ 1□	Yes 2 🗶	No unk	nown			
Division tal or Attendi rs after death. al Directur: A	길	2 Accident Inves 3 Suicide 6 X Could	3	-17-12   of Injury - At hor	fd 2:19 ne, farm, stree		building, etc	c. 28f. Lo	cation (Street	and Number	or Rura	Route Number, City
Is af	Certification:		mined (Specify)	Fd:Resi				_ or	Town, State)	12215 K	dng	s Arrow St.
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	일	20- Cartisian	ysician: To the best			ed at the time	ate and nia	DOW	TC TID.			
thin thin the mple	Medical	one) 2 Medical Exam	<b>niner:</b> On the basis o	examination and	d/or investigat	on, in my opinio	n, death occ	curred at the tim	e, date and p	lace, and due	to the	ause(s)
E 2 E 8	Š	29b. Signature and title of certifier	and manner sta	11.00.		29c. Licen:	se number		29d	I. Date signed	(Month	ı, Day, Year)
		1 Vandal	111			0.0	M.E.			igust 17, 20		
	ŀ	30. Name and address of person	who completed cause	of death (Itom 3	3a)					J , 2		
			sistant Medical		,	Itimore Stree	et. Baltim	ore, MD 21	223			
St	ate		32. Red	istrar's Signatur			.,					
Regist	rar	31. Data 10 <b>2 2 3 2012</b>	Kenua	p. 19	acti							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 28726 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raymond William Barthelow Sr. 2012 August 30. 4:06 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12446 Harvey Rd. Washington Clear Spring Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 212-58-9754 **Director 1X**□M2□F 59 Maryland Jan. 1, 1953 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Washington Clear Spring 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? Funeral 12446 Harvey Rd. 21722 U.S.A Was Decedent of Hispanic Drigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Isaac F. Barthelow Ellen E. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Barthelow (Wife) 12446 Harvey Rd. Clear Spring,Md. 21722 20a. Method of Disposition
1 

Burial 

Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave. **HUIS** M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ mont Due to (or as a c requence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Dther (specify) 2 No detached 9 Unknown 9 Unknown been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{No} \) No 24a. Was an or Attending Physician; The law autopsy performed page Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending injury ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3

gn

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dical

Camus

29d. Date signed (Month. Dav. Year

.30:12

			For	State of M	arylar	nd / Depa	artmer	nt of H	lealth a	and M	ental Hy	giene 🥎	010	20727
	_		State Registrar			Cer	tificat	e of E	Death			Reg. No.	012	28727
	Physicia Medi		Donna M.  Donna M.  1. Decedent's Name (First, Middle, Last  Donna M.  Donna M.	Burkett							2. Date of De Amonth Augus		ZÖIZ	3. Time of Death F
	Exami	ner	4a. Facility Name (if not institution, give				4b. City,	Town, or	Location of	of Death	0		unty of Death	
	- Company		Meritus Medical  5. Social Security Number 6. S		a da um l	last birthday)	Ha (	gerst	If Under	24 Um I	0 D . (D)		hingto	
	Funeral Director		217-42-8949	□ M 2 💢 F		59 Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da April 1	y, Year)	Coun	place (State or Foreign try) gerstown , MI
	show d at	호	Usual Residence of Decedent  10a. State  10b. County		10c. Cit	ty, Town or Loc	cation			<u>t</u>	ipili i	2, 1)-		Od. Inside City Limits
	Mary 28a-f otifie	irec	PA Frankl	in	Gre	encast	1e							1 ☐ Yes 2 🔀 No
	vith the 23a or ist be n	Funeral Director	10e. Street and Number 1451 Brenda Dr.				10f. Zip		17225			10g. Citizen	of What Cour	try?
	death vitems	Fune	11. Marital Status	12. Was Decedent I		S. 13. V	Vas Decec				ify Yes or No- lican, etc.)		Race - Americ	an Indian,
21215-0036	urs after c ural", or	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.	ΧNο				Specify:		lican, etc.)		Black, White, e	
15-(	72 hou n "nat ledica	nple	15. Decedent's E (Specify only highest gra			16a. Deced	and of wor	rk done d	ation uring most	t of workin	g	16b. Kind o	of Business/Ind	dustry
212	vithin giene. er thar the M	Col	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		omema					074	m home	
nd	filed vial Hyg	o Be	17. Father's Name (First, Middle, Last)		-			T	18. Mothe	er's Name	(First, Middle,			
ryla	uld be d Ment marke natic	욘	Arthur W. Eck			т			Hi.	lda M	1. Brow	n		
Ma	d 2 sho alth an 1 27 is 1		19a. Informant's Name/Relationship (T)  Richard W. Bur	,		1					Route Numbe encast1		n, State, Zip C 17225	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2XXCremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Removal from State	C	Place of Disposemetery, crem	sition (Nan natory or o	ne of ther place	e) A1	ue. S	ate 31, 201	20c. Locati	on - City or To	wn, State
Balti	permit. F Departm Importa any inju		21. Signature of Funeral Service Licens		_   Cun	22	. Name an	d Addres	s of Facility	y N	liller-	Bowers		eral Home A 17225
	1 53	Г	23a. Part 1. En or the disease, or comp shock, or leart failure. List only o	olications that caused	d the deat		_							Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		U76	RE	5 P	IRA	70R	TFA	ILV.	Rr	Onset and Death
	Examiner		Tooding in deathy	Due to (or as	a consequ	uence of):	Seu	1-217	T	CH	7 ( 1 0 1)			
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	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:		(7 K	o LY	7 (	/~	BAG	ANCE			
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68760		Med	IF FEMALE:	U										
Вох	The law requires that the death certifics ate has been signed by the attending ppage 2 should be detached for use as	Physician/M		23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	al death 3 🗌	Ectopic p Other (sp		/		,	1	Date of delive Month	ry Day Year
P.O.	that the		Part II. Other significant conditions co	ontributing to death b	ut not res	ulting in the ur	nderlying o	ause giv	en in Part I		23e. Did to	bacco use c	ontribute to the	e cause of death?
ds,	v requires that the speed by the should be detailed by the should be d	Completed by							-		1 🗆 🗅	∕es 2. k⊠ N	o 3 🗆 Prob	ably 4 🗌 Unknown
cor	faw re has be e 2 sh	nple									24a. Was a	sy	prior to con	sy findings available npletion of cause of
Re			05 W									med? 2 2 No	death?	2 🔯 No
/ita	ysician: is certific director,	) Be	25. Was case referred to medical examiner?  1 □ Yes 2 ⋈ No	Hospital:				1.00	ce of Deat		, ,		-	
of V	y Physer this eral di	e: To	27. Manner of Death	28a. Date of inju	ry	ER/Outpatient		Bc. Injury	4 □ Nu		e 5 Resid			
ono	ttending P death. tor: After / the funer	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	(, Year)	injury	M	work?	Yes 2		d. Describe is	ow injury occ	arrea	
Division of Vital Records,	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific itely filled in by the funeral director,	l Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At ho	me, farm, stre	et, factory,	, office		28	3f. Location (S City or Tow		mber or Rural	Route Number,
_	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examironly one) 3 Certifying Nurs	ner: On the basis of e	xaminatior	and/or investi-	gation in n	ny oninior	death occ	curred at th	o time date a	nd place and	due to the equ	eo(e) and mannor stated
	To the within 2 To the comple	-	29b. Signature and title of certifier			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		License		o and place			ned (Month, D	
	, Lan		MUHAMMED	A212				0	668	39Z		8/3	0/12	
	MI		30. Name and address of person who c	ompleted cause of de	eath (Item	23a) (Type, Pr	int)	100		0	d 11 -	مر أ	a 4 · 0	21742
	Stat	le 🔻	31. Date filed (Month, Day Year) 20	12 32 Registra	ır's Signat	g. Joa	Kal	erc.	ump	us n	A Hay	5 2104	<u>~ 140)</u>	31176
	Registra	ar I	Whi - 0 -0	1										

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State of Manyland / Department of Health and Mental Hygiene

			For State Of IVIS	ıı yıarı	•	tificate of			Reg. No	2012	2 28728
	Physicia		1. Decedent's Name (First, Middle, Last)  George Elwood	Blic	ckenst	aff		2. Date of D Month Augus	eath	ay 28 Year 201	3. Time of Death <i>P</i> 2.'06 M
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Meritus Medical Center			4b. City, Town, o	r Location of	Death		County of Deat	h
	Funeral Director			80	st birthday) Yrs.	If Under 1 Year Months Days			ay, Year)	9. Bir Co	thplace (State or Foreign untry) yland
	ıryland • <b>f show</b> ied at	Director	10a. State 10b. County  Maryland Frederick	10c. City.	, Town or Loc	rsville				,	10d. Inside City Limits  ▼▼▼ Yes 2 □ No
	h the Ma ka or 28a be notif		10e. Street and Number		Tiye	10f. Zip Code			10g. Ci	itizen of What Co	1111
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	3 Walnut Street  11. Marital Status  12. Was Decedent E Armed Forces?		. 13. V		773 Hispanic Originan, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	-	USA 14. Race - Ame Black, White	
909	ours after rtural", o al Exam	eted by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced  1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No.		☐ Yes 2 💢 No					Vhite
21215-0036	thin 72 ho ene. <b>than "na</b> he Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4 or 5-	+)	(Give F life. Do	lent's Usual Occu kind of work done O NOT use retired ASSESSO1	during most o )	of working	MD	Kind of Business/ State of essments	
and 2	be filed wi ental Hygid ked other ic event, t	To Be (	17. Father's Name (First, Middle, Last) Harry Garfield Blickenst	l	Iun	110000000	18. Mother	's Name (First, Middle Ladys Ade	, Maiden		, a randeren
Maryland	2 should l th and Me 27 is mark traumation		19a. Informant's Name/Relationship (Type, Print) Robin Schmitt/daughter		1		and Number	or Rural Route Numb	er, City o		
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ce	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or	
Balti	permit. I Departm Importa any inju		21. Signature of Fungral Service Liothsey			Name and Addre		_		ain Stre	
-Min	Physician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death							Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. Due to (or as a	conseque	ence of):	· · · · · · · · · · · · · · · · · · ·	hosi	ſ			> Pa ()
	ted Insit	Examiner	Sequentially list conditions, lifety holding to inner did cause. Enter Underlying Cause (Disease or injury	conseque	ence of p						7.0
0	ficate be executed g physician and as the burial-transit	ical Exa	that initiated events resulting in death) Last C. Due to (or as a	conseque	ence of):		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
68760	¥ වා සි	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of							23d. Date of de	livery
O. Box	he death or the atter	Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnan Other (specify)	cy			Month	Day Year
o.	s tha gnec	by	Part II. Other significant conditions contributing to death by	ut not resu	ulting in the u	nderlying cause g	iven in Part I.				the cause of death?
Division of Vital Records,	sician: The law requires that the death certicesters certificate has been signed by the attendin director, page 2 should be detached for use	Completed	Diebetes Melit	tus b.				per	s an opsy ormed?	prior to death?	topsy findings available completion of cause of
ta	Physician: T r this certifica eral director, p	Be	25. Was case referred to medical examiner?	14~		26. F		(Check only one)	QCJ IV	0 1016	2 110
l of V	ling Physi After this of funeral dir	ate: To	27. Manner of Death  1 Natural 5 Pending  1 Natural 5 Pending	у [	ER/Outpatien 28b. Time of injury	28c. Inju	4 ∐ Nurs ry at k?	sing Home 5 Res			ify)
ivision	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.		me, farm, stre		Yes 2 □ N				ral Route Number,
Ω	Hospital 24 hours Funeral letely filled	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of response only one) 3 Certifying Nurse Practitioner: To the	kamination	and/or invest	igation, in my opin	on, death occi	urred at the time, date	and place	e, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	200. 01 111	,əmouge,	29c. Licens		(C)		ate signed (Month	
	10 lar		30. Name and address of person who completed cause of de	- 11		1	1	Smithsb	1 165	M /	/
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registra  SED 1 0 2012		ure A.	barry	16 ref	SMITHSD	)	1.619160	9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Mandrin Inpatient Care Center Harwood Anne Arundel . Social Security Number 8. Date of Birth Feb. 18, 1913 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Min. Days Hours Months Country) MD 212-46-3306 Director 99 1 🗆 M 2 ី 🕽 F Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shoriury or other traumatic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Lothian 1 🗆 Yes 2 🗗 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5570 Greenock Road 20711 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Someone Else's Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Ennis Hattie Elizabeth Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Burley/daughter 5570 Greenock Rd. Lothian. MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Moses Cemetery 8/21/2012|Lothian, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of FacilitySewell Funeral 1451 Dares Beach Rd. Prince Home, P.A. Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani CANCER OF UTERUS Cars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Tigury that initiated events resulting in death) Last attending physician and for use as the burlal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPER TENSION Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy eral Director: After this certificate I filled in by the funeral director, pag Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 🔀 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) MANDRIN after death.

Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8-14-12 0 14774 DEPONSE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW) M.D SHAHID 212 31. Date filed (Month, Day Registra s Signature State AUG 16 barker Registrar

			1 - For Stata Registrar	State o	f Maryla	nd / Depa	artment of F	lealth and Death	d Mental H	ygien Reg. No		28730
	Physici /Medic		Decedent's Name (First, Middle, La	st) Phi	lip	Syron	Bathor	n	2. Date of Month	Da	b, 2012	3. Time of Death O1:45 A M
1	Examir		4a. Facility Name (If not institution, giv 75 Riverside Dri		nber)		4b. City, Town, o Elktor		eath	40	County of Deat	h
	Funeral Director		210-22-3201	Sex M∑M 2□F	7. Age (In yr. 86	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Month. May 20	Birth Day, Year 5, 19	9. Birt 26 M	hplace (State or Foreign buntry) aryland
	ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or Lo	cation					10d. Inside City Limits
	the Ma	ecto	Maryland Cecil			E1kton	10f. Zip Code			10- 6	itizen of What Co	1 □ Yes 2 🗓 No
	th with 23a or	a Di	75 Riverside Dri	ve			21921				United S	,
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic avant, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🎇 Widowed 4 □ Divorced	12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or Da	rces? 2∏No e		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Ame Black, White Specify:	
21215-0036	72 hou	eted	15. Decedent's Ed (Specify only highest gra	ducation		(Give	dent's Usual Occup	during most of v	working	16b. F	Kind of Business/	
2121	d within giene. or then	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		oo notuse retired ster Elec	·	n		Electric	ca1
and	I be file ntal Hyg ed othe avant,	Be	17. Father's Name (First, Middle, Last)						Name (First, Midd		n Sumame)	
Maryland	should and Me mark umatic	ţ.	George Howard Ba  19a. Informant's Name/Relationship (		r <b>.</b>	19b. Mailir	ng Address (Street		Marie Sy: Rural Route Nun		or Town, State, 2	Zip Code)
	l and 2 lealth a im 27 iu		Jane B. Konowitz	/Daughte		111	Pine Vall	ey Road	l, Elkton			
mor	Pages lent of H nt: If its ry or ot		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Qonation 5 □ Other (Specif		State In	cemetery crec	natory or other place te on Cemete		gust 30,		ocation - City or Cherry H	
Baltimore,	permit. Depertm Imports any inju		21. Signature of Funeral Service Licer		45	22		ss of Facility	Hicks Ho	me f	or Funer	als, P.A.
I			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the de			g, such as card	lac or respiratory	arrest,		Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (	or as a conse		ancer					Unknown
	Examiner	_	Sequentially list conditions,	b								
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a conse	equence of):						
8760,	icate be executed physicien end s the burial-transit	al Exa	resulting in death) Last	Due to (	or as a conse	equence of);						
Φ	tificate ig physi es the	ledical		_ d.								
P.O. Box	The law requires that the death certifi sie hes been signed by the ettending page 2 should be deteched for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 ☐ Fe ant at time of	tal death 3	Ectopic pregnancy Other (specify)				23d. Date of deli Month	ivery Day Year
ords, P	w requires that been signed b should be dete	by	Part II. Other significant conditions of	ontributing to de	ath but not re	esulting in the ur	nderlying cause give	en in Part I.		tobacco		the cause of death?
Division of Vital Records,	w	Completed							ре	is an lopsy formed?	death?	topsy findings available completion of cause of 2□ No
Ž	Physician: rthis certifice ral director, I	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 li	npatient 2[	☐ ER/Outpatien	t 3 DOA Othe		Death <i>Check on</i> Home 5 Re		6 ∏Other (Spec	cifv)
o uoi	Afte	Certification: 7	27. Manper of Death  1 Natural 5 Pending 2 Accident investigation	1		28b. Time of Injury	28c. Injun Work		28d. Describ			,
DIVIS	or Attu efter de Directo	ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At ng, etc. (Spec	home, farm, stri cify)	eet, factory, office		28f. Location City or 7	(Street ar own, State	nd Number or Ru e)	ıral Route Number,
	To the Hospital or Attend Mithin 24 hours efter death To the Funeral Director: Sumpletely filled in by the	Medical C	29a. Certifier 1 Certifyin , Ph (Chack only one) 2 Medical Exam	ysician: To the niner: On the ba and mann	isis of examin	nation and/or inv	offulfed at the three vestigation, in my or	ie, date and pla pinion, death oc	ice, and dua to the courred at the time	e daus J(s e, date an	) and munt er us d place, and due	stated. to the cause(s)
	To the within 2 To the	×	29b. Signature and title of certifier	2 (	///		29c. License				ate signed (Monti	
	JAN		30. Name and address of person who	completed cause	M)	am 23a) (Tuno	Print)	02332	2- M		8.27.	20/2.
	10 Dr.		5. S. SACHIDE	u MD,	S. South (Ite	nature	High ST	Ell	Ton MI	24	2/	
	Sta Registr		31. Date filed (Month, Day, Year) <b>SEP 1</b> 0 2012	32. R	egistrar's Sign	nature face	and a					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #6, per fh, g931 9-7-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $28^{\text{Day}}$ Physician/ Month Dorothy W. Berkheimer 2012 August 1015 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Union Hospital **Elkton** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Hours Months New York 115-24-5644 80 **Director** 7/16/1932 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil Earleville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Cecil Road 21919 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Finger Catherine Bromm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Lind-Daughter 13 Needle Leaf Dr. Newark, DE. 19702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brandywine Valley Cremation Care 8/30/2012 Wilmington, DE. erral ve of Funeral Service Licensee 22. Name and Address of Facility Chandler Funeral Homes 2506 Concord Pike, Wilmington, DE 19803 CC0283 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \sum \text{ Yes} \quad 2 \sum \text{No} \) 3 Ectopic pregnancy Month Year Day 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s has autopsy perform death? After this certificate 2 **X** No 1 ☐ Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Names Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie MV D0062190 8/28/12—
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ CHAN MD
2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAFEAKEUTY, MD 2195 Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Maurice Cecil Chuang 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 19, 2012 0420 hrs Medical Examiner Maurice Cecil Chuang 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 301 Light Street 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 09/07/1993 18 Country) 217-39-8775 1 X M Usual Residence of Decedent 0c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No Baltimore hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21202 620 Falls Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes White Yes 2 X No specify: Divorced If Yes. Give Year Specify marked other than "natural", event, the Medical Examiner Š 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. Auto Detailing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivolene Wiles Michael Chuang portant: If item 27 is marked ury or other traumatic event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivolene Wiles / Mother 620 Falls Way, Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 08/31/2012 Clinton, MD Lee Crematory Donation 5 Other Specify: 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signator of Funeral Service Licensee 8200 Jennifer Lane, Owings, MD 20736 Gary GOIL Approximate Interval 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed sician/Medical AMENDED 23a, 27, 28a-f, per me, g931 9-11-12 sm physician a X UNPENDED Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death Month Year past 12 months? Pregnant at time of Other (Specify) death Unknown Yes 2 No 9 Unknown ned by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed' ✓ Yes 2 1 🗸 Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Other<sub>4</sub> examiner? Hospital: Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes 28d. Describe how injury occurred After 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Natural Division 1 Yes 2 X No fd 8-19-12 death. 5 Pending fd 3:28 am subject drowned 2 X Accident Investigation within 24 hours after de To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 301 Light St. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) harbor Baltimore, MD. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 19, 2012 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year,

AUG 2 9 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #25 per MD FCHD TM 8/29/12 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Ray Comulada Jr Month August 2012 2:07 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 220-40-5077 1 **№** M 2 □ F 71 June 25, 1941 Connecticut Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 90 Waverly Dr., Bldg. GG 302 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give 1963-65 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Office Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Elizabeth Dziomba John R. Comulada, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 Waverly Dr., Bldg. GG 302, Frederick, MD 21702 Corinne Comulada / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation Resthaven Crematory Frederick, Maryland 5. Otney (Specify) 21. Signatur of Funeral S rice Licensee Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy.

Physician/ Medical Examiner For State Registrar

10a. State

Director

Funeral

þ

Completed

Be

2

Physician/

Medical

**Examiner** 

**Funeral** Director

or 28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examine within 24 hours after death

To the Funeral Director: A

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	23a. Part 1. Enter the disease, or complic shock, or feart failure List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not enter the cause on each line.	mode of dying, such as cardiac c	r respiratory arrest,		Approximate Interval Between Onsetland Death
l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ia			1-2days
Completed by Physician/Medical Examiner	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No g Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
completed by Pl	Part II. Other significant conditions cont Quadriplegia Acute fevor Failu	ributing to death but not resulting in the underly Pontine Stoke (previous	ving cause given in Part I.		2 No 3 P	the cause of death?  robably 4  Unknown  topsy findings available completion of cause of
To Be (	25. Was case referred to medical examiner? 1 X Yes 2 And Ho	pspital: 1 X Inpatient 2  ER/Outpatient 3  ER	26. Place of Death (Check			-22.21.2
ficate:	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury  M	28c. Injury at work?	28d. Describe how inju		
I Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office	28f. Location (Street a City or Town, Stat		ral Route Number,
Medical Certificate:	(Check 2 ☐ Medical Examiner	ian: To the best of my knowledge, death occurr r: On the basis of examination and/or investigation Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at	the time, date and place	ce, and due to the	cause(s) and manner stated.
_	29b. Signature and title of certifier MM		29c. License number		2 1 2 201	

Frederick, MD

Registrar

State

31. Date filed (Month, Day, Year)

AUG

ess of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Crystal Renee Crab	b State of Maryland / Department of 1-For State Certificate of Registrar		lygiene 201	2 2873
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Crystal Renee Crabb		2. Date of Death  Month Day Year August 22, 2012	3. Time of Death . 1010 hrs
	4a. Facility Name (if not institution, give street and number) 436 McDowell Avenue	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington	1
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs Months Days Hours Min	Foreig	
More, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Int: If item 27 is marked ruler than "natural", in items 23a in 28a-f aliniw any in ruther traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10a. State   10b. County   10c. City, Town or Local Haryland   Washington County   Hagerstown   10e. Street and Number   436   McDowell Ave.   12. Was Decedent Ever in U.S.   13. William   15. Never Married   2   Married   15. Decedent's Education (Specify only highest grade completed)   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   13. William   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15. Decedent Ever in U.S.   15. William   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent Ever in U.S.   15a. William   15a. Decedent Ever in U.S.   15a. Decede	10f. Zip Code 21740 as Decedent of Hispanic Origin? (Sr fes, specify Cuban, Mexican, Puerto Yes 2 \( \times \) No specify: nt's Usual Occupation (Give kind of values of working life. DO NOT use reticted points of the compact of the	PRican, etc.) White, etc.  Specify: Whitework done 16b. Kind of Business/li	can Indian, Black,
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked nither the injury or nither fraumatic event, the Med To Be Comp	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22b. Place of Disposition crematory or other Specify:  21. Signature of Funeral Service Licensee  22b. Place of Disposition crematory or other Specify:  21. Signature of Funeral Service Licensee	sition (Name of cemetery, her place)  12 Crematory 8-2 Name and Address of Facility Doug	gerstown, MD 21740  Date   20c Location - City or   24-2012   Smithsburg glas A. Fiery Funer NorthHagerstown, N	g, MD cal Home
Physician /Madical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter to failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ne mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
50, te be executed ysician and burial - transit	if any, leading to immediate cause. Enter Underlying Cause (Ciseose or if the that whiteled events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  UNPENDED  AMENDED	-		
ertifica ding ph	23c. If yes, outcome of pregnancy 1 Live birth 2 In the past 12 months? 2 Pregnant at time of death	ntal death 3 Ectopic pregna	23d. Date of delivery  Month  D	ay Year
Records, P.C. The law requires that cate has been signed page 2 should be deter	Part II. Other significant conditions contributing to death but not resulting in the u		autopsy prior to condeath?  1 Yes 2 No 1 Yes	ably 4 Unknown
Vital F ysician: his certifi director,	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check of Other 1) DOA Other 1 Nursing	only one) g Home 5 Residence 6 ✔ Other:	
ion of Vi tending Physi eath tor: After this the funeral dir ation: To	1 ✓ Yes 2 No 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation  1 Natural 1 Natural 1 Natural 2 Natur	njury 28c. Injury at Work?	28d. Describe how injury occurred Subject hanged self	Scene
Division o  To the Hospital or Attending within 24 hours after death to F Rueral Director: Aft completely filled in by the funce ledical Certification:	3 ✓ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) Single Family Home		28f. Location (Street and Number or Rur or Town, State) 436 McDowell Avenue, Hagerstown	100 II
Divi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one)  2 Medical Examiner: On the basis of examination and/or investigat and manner stated	ion, in my opinion, death occurred at	due to the cause(s) and manner as state t the time, date and place, and due to the	d. cause(s)
>	29b. Signature and with of certifier	29c. License number O.C.M.E.	29d. Date signed (Mon August 23, 2012	th, Day,Year)
IW-1	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Ba	ıltimore Street, Baltimore, M	MD 21223	
State Registrar	31. Date filed (Month, One Year) 32. Registrar's Signature	nes!		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 28c, per me, g931 9-10-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Auq. Charles Currey a/k/a Charles Bruce Currey 24 1:30 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Baltimore Towson . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) 217-94-6517 Director 1 X M 2 - F 46 Yrs 1966 MD Jan. 6, ortent. If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other treumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City. Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1424 Armacost Road 21120 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 X Married should be filed within 72 hours after or and Mental Hygiene.
Is marked other than "natural", or ☐ Yes 2 🖾 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Excavator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Brady Currey Carole Anne Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 street of Health a tent; If item 27 is Kim Currey/Wife 1424 Armacost Rd. Parkton, MD 21120 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Importent: If ite eny Injury or ot Date Pine Grove of the ed Methodist Cemeter 1 XBurial 2 Cremation 3 Removal from State Aug. 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2012 Parkton, 21. Signature of Funeral Privice License 22. Name and Address of Facility JJ Hartenstein Mortuary, 24 N. second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Anaphiaxsis

Due to (or as a consequence of): Physician/ ue disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Duri to for as a nonsequence on To the Hospital or Attending Physiclen: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred anaphy laxis 1 Natural 2 Accident 5 Pending injury 1 X Yes 2 X No 24/2012 1158 A due to Bee stind Investigation 3 Suicide
4 Homicide 6 Could not be lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura Foute City or Town, State) 24 34 Garage City or Town, State Work site ONSTRUCTION hite Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one and title of certifier 29b. Signature 29c. License number 1866 rson who completed cause of death (Item 23a) (Type, Print) 6 Truble Hill 31. Date filed (Mor to, Day, Year) State Registrar

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harles

12-06436 Ollie F. Cotton

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State of Maryland / Department of Health and Mental Hygiene	Same !	0	J Lan	20	10

		1- For State Registrar	2 Date of Death   2 Date of Death   3 Time of Death   3 Accounty							
Physic dedical Exan		Decedent's Name (First, Middle, Last)     OLLIE FRANCES COTTON								
			ımber)			4c. County of Death				
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		If Under 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Bir				
Directo			81		Hours Min. Oct	10 1930 Foreig				
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits			
Maryland 28a-f show	ē	PA Philadelphia	Philadelp				thplace (State or granulary) PA  10d. Inside City Limits 1 X Yes 2 No  ntry?  ican Indian, Black,  Black Industry  DME  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Soably 4 V Unknown  topsplittings available for services and interval  pastly 4 No  Scene			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If it item 27 is marked other than "matural", or items 23s or 28s-f sho inlury or other fraumstic event. the Medical Examiner must be notified as once	Director	10e. Street and Number 514 S. 55th St.		1			ntry?			
ath with items 23	Funeral	1 Never Married 2 Married Armed F.	orces?				can Indian, Black,			
after de Ll", or i	by Fu	3 X Widowed 4 Divorced If Yes, Give Yes	Control Court Power (Prist, Middle, Last)  Charles FRANCES COTTON  Charles FRANCES COTTON  August 26, 2012 Year August 27, 2012 Year Au							
hours nature	ted b		during			16b. Kind of Business/I	ndustry			
036 rithin 72 ene. rr than '	Completed	12		etaker-Hous	sekeeper	Private Ho	ome			
21215-0036 build be filed within 7 Mental Hygiene. marked other the Medica	ပ္ပ	17. Father's Name (First, Middle, Last)  Bill Fleishmen				Maiden Surname)				
212 ould be d Ments s mark	10 B	19a. Informant's Name/Relationship (Type, Print )	19b. Ma			mber, City or Town, State	Zip Code)			
MD and 2 she ealth and cen 27 is		Cynthia Oakley (daug					Town State			
nore ages 1 and of Ho at: If it		1 X Burial 2 Cremation 3 Removal fr	om State crematory or	r other place)						
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee								
Physician							Approximate Interval			
/Medica Examine	\$ 10	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease								
		h	consequence of):							
	iner	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause	consequence of):							
led nsit	Examine	events resulting in death) Last Due to (or as a	consequence of):		,					
760, cate be executed physician and the burial - transit	Medical									
8760, ificate be ig physic s the buri	n/Me	23b. Was decedent pregnant in the	:	Fetal death 3	Ectopic pregnancy		av Year			
i, P.O. Box 687 ires that the death certific signed by the attending is be detached for use as if	Physician/	past 12 months?	nant at time of death 5	_			-,			
O. B. It the de by the	Phy			ne underlying cause give	en in Part I. 23e. Did t	obacco use contribute to t	he cause of death?			
S, P.O. uires that the n signed by id be detacl	ed by	Addison's Disease; Diabetes Mellitus	s; Renal Disease							
cords, law requir	Completed			··· <u>-</u>	auto	autopsy prior to completion of cause of				
Vital Recorbysician: The law 1	Co	25. Was case referred to medical		26.Place of	1 Yes	2 ✓ No 1 Ye	s 2 No			
Vita hysicia this cer al direct	To Be	1 Yes 2 No		15a. Decedents Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Caretaker—Housekeeper  18. Mother's Name (First, Middle, Maiden Surname)  Frances Dent  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  25647 West Hill Rd. Worton, MD. 21678  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State)  25c Location - City or Town, State  25c Location - City or Town, State  Coleman, MD.  23dres and Address of Facility  Home of Stephen L Schaech  18 West Cross St. Galena, MD.  21 Schaech  25d Approximate Interval Between Onset and Death  Do not enter the mode of dring, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval Between Onset and Death  Do other (Specify)  25c Place of Death (Check only one)  25c Place of Death (Check only one)  25c Place of Death (Check only one)  ERVOutpatient 3 DOA Other's Nursing Home 5 Residence 6 Other Scene  25c Place of Death (Check only one)  ERVOutpatient 3 DOA Other's Nursing Home 5 Residence 6 Other Scene  25c Place of Death (Check only one)  25c Place of Death (Check only one)  25d Time of Injury 25c Injury at Work?  1 Yes 2 No  25d Describe how injury occurred  1 Yes 2 No  25d Describe how injury occurred  25d Location, Gircet and Number or Rural Route Number, City or Town, State)  25d Canes and Death occurred at the time, date and place, and due to the cause(s) and manner as stated.  25d Canes and Death occurred at the time, date and place, and due to the cause(s) and manner as stated.  25d Describe how injury occurred  25d Location, In my opinion, death occurred at the time, date and place, and due to the cause(s)  25d Describe How Town, State)  25d Describe How Town, State)						
Division of Vital Records, tal or Attending Physician: The law requir as after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be led in by the funeral director, page 2 should led.			of Injury , Day,Year) 28b. Time		_	how injury occurred				
Visior or Attend fler death Director: in by the	Certification:	2 Accident Investigation 28e Plac	e of Injury - At home, farm, s	street, factory, office build			al Route Number, City			
Ospital ospital hours a nneral I		4 Homicide determined (Specify)								
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as I	Medical	one) 2 Medical Examiner: On the basis of	of examination and/or investi							
F 3 F 3	ž	29b. Signature and title of certifier	0:0				th, Day Year)			
SM			se of death (Item 23a)	U.C.M.I	E.	August 27, 2012				
30'		Patricia Aronica-Pollak MD. Assista	ant Medical Examiner		re Street, Baltimore, M	D 21223				
Regi:	state strar	31. Date filed (Month, Day, Year) SEP 1 0 2012	egistrar's Signature	all						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #25 per MD FCHD TM 8/22/12
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 11 30 AM Kyan Dawson Roia Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mayland medical Center Baltimore Inversity If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) 220-17-9224 **Director** 1 🔀 M 2 🗆 F 2/2/1987 25 WV. Usual Residence of Decedent show 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1X Yes 2 No Frederick Brunswick MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 510 9th Ave. 21716 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give be filed within 72 hours after 1 ☐ Yes 2 ▼ No Specify. Specify: 3 Divorced 4 Divorced White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur: any injury or other traumatic event; the Medical Eonce. 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Rehabilitation Center Scott Key Center Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Patricia Darnell Heaton Ryan Lee Dawson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 9th Ave. Brunswick MD 21716 Patricia Heaton, Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8/21/2012 Hagerstown Crematory Hagerstown MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lio by e 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Intracerebral Physician/ herontinge disease or condition resulting in death) 1 das Medical Due to (or as a consequence of): Examiner dural Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine (or as a sunsequence of) Cause (Disease or injury signed by the attending physician and id be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, Hyperlipidemia should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy performed death? Yes 2 No 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 X Yes မှ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 28c. Injury at 1 Natural injury work?
1 Yes 2 No 5 Pending within 24 hours a er death.

To the Funeral Director Af Investigation Accident filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) David Hende MI 8/18/12 1669764692 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Heish

AUG 22

31. Date filed (Month, Day, Year)

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In

H

22 S. Greene St

32. Registrar's Signature

Suite 127

Baltimare, MD

21201

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State of Maryland / Department of Health and Mental Hygiene

				or waryland	Certif	icate of D	eath_		Reg. No. 2	012	28738	
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Maxine Deloris DALES					2. Date of Dea		2012	3. Time of Death A	
Examin			4a. Facility Name (if not institution, give street and r Meritus Medical Center	41		Location of Death		4c. County of Death Washington				
	Funeral Director		5. Social Security Number 577-38-4186  Usual Residence of Decedent	7. Age (In yrs. last I		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day March 4	, Year)	9. Birthpla Country	·	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ctor	10a. State 10b. County		own or Location					10	d. Inside City Limits		
	Director	Maryland Washington  10e. Street and Number	Ke	eedysvi	Llle Of. Zip Code			10g. Citizen of	What Countr	1 Yes 2X No		
	Funeral	18 Turkey Tract Place				756		USA		,		
9800	ırs after deat ıral", or iter I Examiner ı	by	Armed		If Yes	Decedent of His s, specify Cubar Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, et whi	С.	
15-0	72 hou in "natu Medica	Completed	15. Decedent's Education (Specify only highest grade complet	ed)	(Give kind	's Usual Occupa of work done do OT use retired)	tion uring most of wor	king	16b. Kind of B	usiness/Indu	stry	
212	d within lygiene. ther tha nt, the I	Be Co	12 0	(1-4 or 5+)	housew	,			her ov		e	
/Janc	d be file Jental H Irked or Itic evel	To E	17. Father's Name (First, Middle, Last) William Nation				18. Mother's Nan <b>France</b>	s Welsh	Maiden Sumam	e)		
, Maryland 21215-0036	nd 2 should ealth and M m 27 is me		19a. Informant's Name/Relationship (Type, Print)  Adrian Dales - son			Address (Street and Number or Rural Route Number, City Montvale Dr., Silver Spri						
more			20a. Method of Disposition  1 ☐ Burial 2 🎛 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State ceme		ry or other place	) ory 8/30	Date 0/12		-	n, State Maryland	
Baltı	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	in Qu	22. Na	ame and Address	s of Facility MIN	NICH FU	NERAL H	OME		
L	**********		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on	each line.	o not enter th	e mode of dying	, such as cardiac	or respiratory arr		1	Approximate nterval Between	
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	to (or as a conseq and	atic ce of):	Ence	phlopa	thy		4	Onset and Death  Weeks.	
		er	Sequentially list conditions, b.	L'U	Cirrho	1130		U	inknown.			
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
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9/8	rtificate ing phy e as the	/Medical	IF FEMALE:			-						
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	ires that the signed by do be deta	ρ	Part II. Other significant conditions contributing to Price	umonia			en in Part I.				cause of death?	
Sord	aw requas been 2 shou	Completed	Ro	nal Fo	ailure	2.		24a. Was an autopsy finc prior to completio				
Ř	n; The la ficate ha		25. Was case referred to medical					1 Perfor	med?	death? 1 🗌 Yes 2	_	
Vita	hysicial nis certi Il directo	To Be	examiner?	Inpatient 2 ER/	Outpatient 3	Othor	ce of Death (Chec	ome 5 🗆 Resid	ence 6 🗌 Oth	er (Specify)		
Baltimo Baltim	ertificate:		te of injury 28t onth, Day, Year)	o. Time of injury	28c. Injury at work?  M							
DIVISIO	al or Atter s after dea al Director ed in by the	O	3 Suicide 6 Could not be		street, factory, office 28f. Location			n (Street and Number or Rural Route Number, Town, State)				
_	Hospit 24 hour Funera etely fills	Medical	29a. Certifier (Check 2 Medical Examiner: On the top to the control of the contro	pasis of examination and	d/or investigati	on, in my opinior	i, death occurred a	it the time, date ar	nd place, and du	e to the caus	e(s) and manner stated.	
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practition  29b. Signature and title of certifier		7-		29d. Date signed (Month, Day, Year) August 28, 2012  Source MD 21713					
	CZ		30. Name and address of person who completed ca	use of death (Itom 02	a) (Type Print)	2 4	14996		4ugust	28,	2012	
	10		Cafar Mali	K Mp	203116	appar	is Red	Aconsb	oro iv	0 2	1713	
	Stat Registra	e ır	31. Date filed (Month, Day Year) 2012 32	Tegistrar's Signature	bar	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 24 2:15 P M JODY LYNN DOWLER August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County 613 Palm Beach Drive <u>Hagerstown</u> Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 215-76-7782 51 **Director** 1**X X**M 2 □ F March 4,1961 Maryland 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Examiner must be notified at Director X☐ Yes 2 ☐ No Maryland Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 21740 USA 613 Palm Beach Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ö þ 1 Never Married 2 X Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify Specify. "natural", 3 Widowed 4 Divorced White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72., h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Distribution Company Receiver 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Richard Dowler Nellie Ruck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or are Melissa Ann Dowler / Wife Palm Beach Drive, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 28,2012 Hagerstown, Maryland Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service License once. 1331 Fastern Blvd. N. Hagerstown MD 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between esophaseal cancer Ons to d Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy After this certificate has been signed by the atter in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No I or Attending Physician: I after death. Director: After this certifice completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital or within 24 hours aft To the Funeral Dir Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month

who completed cause of death (Item 23a) (Type, Print)
, ~0 //30 oppl +,

D0068995

Hagerstown, MD 21740

8/28/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical give street and number, Facility Name (if not institution, 4b. City Examiner Town, or Location of Death County of Death If Under 24 Hrs. 7. Age (In yrs last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🖫 F (Month, Day, Ye Days Months **Director** , or items 23a or 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 🔨 10g. Citizen of What Country? Funera naton 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 after 1 Yes 2 No If Yes, Give Year or Dates Specify and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) eta: other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle ည þe and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn Department of Health Important; If item 27 Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 🗹 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other injury or 25 Market Cen E.N. Market 4 Donation 5 Other (Specify) permit. HOME, P.A. Signature of Funeral Service Licensee 22. Name and Address of Fallity
Henry Funeral any Henry MD.21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CANCER Physician/ METASTATIC (OLON disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Due to for es a consecuence of cause. Enter Underlying Cause (Disease or linjury that initiated events Exami burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 attending physical for use as the b IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death the detached g 🗌 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deal 28c. Injury at Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated з 🗌 To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D69234 MD D 8 21 2012 e and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nai ERPABOLU MD 2613. CAMBRIDGE 51 EEVAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year veer Medical ne (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charles Waldorf 44 Brookside Place . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 216-50-6742 Months Days Hours Min. 66 **Director** 946 Waldorf, MD Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Waldorf MD Charles 1 X Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 44 Brookside Place USA ral", or items ! death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes Give "natural", Specify Black 3 X Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Thompson Frances Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20601 Samantha Thompson/daughter 44 Brookside Place, Waldorf, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 0 H 6 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Page Department Important: It any injury or 8/20/2012 Riverdale, MD Riverdale Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Se e License 22. Name and Address of Facility Tyrone J. Young Funeral Svcs. 5635 Eads Street, NE Wash., DC 20019 23a. Part 1 Enter the disease, that caused the death. to not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List or Immediate cause (Final on each line Onset and Death Physician/ Cancer of Uterus disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examir signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated by page 2 should b Completed 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 🛚 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D28352 8/20/2012 M.D., F.A.C.P.

Registrar

F.A.C.P., P.O. Box 2729 La Plata, MD

20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Krishan Mathur, M.D.,

31. Date filed (Month, Day, Year)

UG 2 3 2912

12-06238

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Granville Hudson 2012 28742 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 18, 2012 2015 hrs Medical Examiner GRANVILLE H. HUDSON 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Worcester Atlantic General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** reign MARYLAND Country) Months Davs Hours 215-36-0740 Director 12/03/1940 1XM 2F 71 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County SELBYVILLE SUSSEX 1 X Yes 2 No DELAWARE nr items 23a or 28a-f shomust be notified at once. hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 19975 114 EAST TINGLE DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes WHITE 1 Yes 2 No specify: If Yes, Give Year 4 X Divorced Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked nither than ". VENDING MACHINES ROUTE MAN 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DORIS WIMBROW GRANVILLE R. HUDSON Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14216 SPRUCE AVENUE, CHESTER, VIRGINIA 23836 KATHLEEN H. BURNETTE/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State itimore, 1 Burial 2 X Cremation 3 Removal from State MELSON OF CREMATORY 8/24/2012 FRANKFORD, DELAWARE Donation 5 Other Specify: Melson füneratiikservices, LTD. 43 Thatcher Street, Frankford, Signature of Juneral Service Licenses DELAWARE 19945 of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician /Medical Between Onset and Death a Occlusive Right Coronary Artery Thrombus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 8 23e. Did tobacco use contribute to the cause of death? signed by the detacher Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ğ 1 Yes 2 No 3 Probably 4 Unknown Records, P. Colon Cancer: Renal Disease Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other: Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA After this 1 Yes 28a. Date of Injury (Month, Dey, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death within 24 hours after deau.

To the Funeral Director: A 1 V Natural 1 Yes 2 No Pendina Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. August 19, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack/Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ HINRY MARMEL 2012 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 X M 2 □ F 262-96-9512 58 Usual Residence of Decedent 08/30/1953 Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Callaway Maryland St. Mary's 10f. Zip Code 10e. Street and Number r items 23a or iner must be r 10g, Citizen of What Country? 'n Completed by Funeral 44867 Callaway Farm Lane 20620 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc 1 Never Married 2 Married ò 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur. other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Banking Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Henry Harmel, Jr. Mary Elizabeth Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44867 Callaway Farm Lane, Callaway, MD 20620 Thelma Harmel/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or oth X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 08/27/2012 | Leonardtown, MD Charles Mem. Gardens 21. Sign Avre of Funeral Service Licen 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 60 30195 three Notch Rd., Charlotte Hall, MD 20622 MOO817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CAME M DE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions any, leading to immediate cause. Enter Underlying HOURS Exami METABOLIC Cause (Disease or injury that initiated events resulting in death) Last use as the burialattending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 L g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AUTIC VACVE NEWSWI 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown CHRINC KITTNEY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsy performed? death?
1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 24 hours after death Funeral Director. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier D56096 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEON/AND TOWN 20650 STUMBY'S 1708/17AL By NI CAL 67:12 32 Registrar's Signatu State Registrar

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Annie Lee 2012 8:10A August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown Social Security Number If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-36-8197 Director 1 🗌 M 2 🛣 F 96 Usual Residence of Decede 02/15/1916 Virginia 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 X No St. Mary's Maryland Avenue ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r items 23a c Funeral 20609 USA 22695 Maddox Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural", 3 Nidowed 4 Divorced Specify: White Completed er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ပ္ Joseph E. Pingleton Elizabeth Clark : If item 27 is marker or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box Avenue, MD 20609 Myrtle B. Thompson/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State Department o Important: If any injury or Sacred Heart 08/25/2012 4 Donation 5 Other (Specify) Bushwood, MD Signature of Funeral Service Ligens Name and Address of Facili Mattingley-Gardiner Funeral Home, P. 590 Fenwick Street Leonardtown, MD 2<u>0650</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Stroke Medical resulting in death) Due to (or as a consequence of) Examiner Failure to Thrive Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Atrial Fibrillation and the burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No s after death Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 29d. Date signed (Month. Dav. Year) D070900 08/22/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirandeep Kaur 6934 Aviation Blvb., Glen Burnie, MD 21061 31. Date filed (Month, Day, Year, State AUG 2 Registrar

		1 - For State of Maryland / E	Department of F	Health and M Death	lental Hygie	ne 2012	28745			
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/Medic Examin		4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Death				
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William	David	Hammer

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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I compelety filled in by the funeral director, page	E	(Official of it)	Physician: To the best of caminer: On the basis of ex	my knowledg	je, death occur nd/or investioa	rred at the t	time, date opinion.	e and place, an death occurred	d due to the ca at the time, dat	use(s) and te and plac	manner as st e, and due to	ated. the caus	e(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Ta Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Medica 8. Date of Birth (Month, Day, Year) 7 / 31 / 1949 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** 220-50-9915 Director 1 X M 2 □ F 63 D.C. 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1X Yes 2 ☐ No Charles La Plata MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number by Funeral 20646 USA 7160 Annapolis Woods Road 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Library of permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) Elementary/Secondary (0-12) Lead Mail Assistant Congress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Doris Mae Barnes Albert Haywood Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7160 Annapolis Woods Rd., La Plata, MD Donna Hamilton/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State Mem'l Gdn's 8/23/12 Dunkirk, MD 4 Donation 5 Other (Specify) So. 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Service License PO Box 430, Dunkirk, MD 20754 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Interv Ptrysiciani disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to himselful cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe 1 Yes 2 No Yes this certificate 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JRW

31. Date filed (Month, Day,

Greene

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 1 - For State Registrar 28748 Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ August 12, Betty Maxine Henley 1925 6:30a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 10112 Scouts Circle Walkersville Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) 491-22-1790 Months Hours Director 1 □ M 2 🖾 F Yrs 88 Sept 14, 1923 Usual Residence of Decedent Kansas ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 K No Maryland Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10112 Scouts Circle United States 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager HVAC Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ George Charles Milne Cora Taggart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Holt / Son 10112 Scouts Circle Walkersville, Maryland 21793 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place August 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 15, 2012 Frederick, Maryland 21. Signat ve of Fur eral Se 22. Name and Address of Facility Stauffer Funeral Homes, P.A. a lan 40 Fulton AVenue Walkersville, Maryland 21793 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Carch Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year 1 Yes 2 to 9 Unknown the 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes 2 No Yes 2/2N Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ After this of funeral directions 1 Inpatient 2 XER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: After t 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending work?
1 Yes 2 No within 24 hours after death

To the Funeral Director; A

completely filled in by the f Accident Suicide Investigation Could not be 6 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the basis of my should be contained at the time. (Check

State Registrar 29b. Signature and title of certifie

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31. Date filed (Month, Day, Year) AUG 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MD, FACC

32. Resistrar's Signature

arke

29c. License number

D 0057107

180 Thomas Johnson D

29d. Date signed (Month, Day, Year)

MO 21702

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Frederick

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month G H111 Alice August 2012 11:55A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince georges Hyattsville St Thomas Moore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 10 Dec 1922 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 😾 F Hours **Director** 579-20-0147 89 Washington DC Usual Residence of Decedent within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Temple Hills 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 United states 6003 St Moritz Drive #204 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iter Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 Specify: Black 1 Yes 2x No Specify: "natural", Completed 3 Widowed 4 X Divorced Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Department of Commerce Elementary/Seconday (0-12) College (1-4 or 5+) the Chief Manager Twelfth US Federal Government One Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Cheek Mary Rae 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6003 St Moritz Drive #204, Temple Hills MD 20748 Elaine P. HOdges/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State August 30, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory! Beltsville, Maryland 2012 21. Signature of Funeral Service License 22. Name and Address of Facility Robert G Mason Funeral Home Inc 1661 Good Hope Rd SE Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Retween Immediate Cause (Final Onset and Death Physician/ ANTENIOSCLEROTIC CARDIOVASCULGA disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to in the cick cause. Enter Underlying Examine Unit to for as a consequence of attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical to the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Day Year been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Demental Respiratory ta: 10 ve L ventilutor Dependent Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Encephalopathy/ Coronary artery Disease 24a. Was an autopsy Sacrol DICUSITUS / Protein malnutrition/ Frailty certificate 1 ☐ Yes 2 ☐ No Yes 2 No Director: After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Kartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D01852 AUGUST 3 ZO12

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State Registrar GUI

secusiony Rd Hyattsville MD 2078

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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egistrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 5:35 1115 2012 Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Tonta omeru ockv rove entis 9. Birthplace (State or Poreign Country) 8. Date of Birth (Month, Day, 0'8 - 21 -Year If Under 24 Hrs 7. Age (In yrs. last birthday, **Funeral** 1 XM 2 - F Hours Min. Yrs. **Director** Usual Residence of Decedent 28a-f show at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified once. 1 XYes 2 □ No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Ric 14421 Branch 20878 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2-No Asian 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ lam KHAN, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Sai Rich No Potomac tather 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08 21 -rederick ND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Funera HO# 1070 en 2219 Cco disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the Approximate ure. List only one cause on each line. Interval Between Onset and Death shock, or boart 1 Immediate Cause (Final 1eak Physician/ air 5 yndrome disease or condition Medical resulting in death) **Examiner** tor espiva Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of The law requires that the death certificate be executed prematurit and that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year 1 Yes 2 No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No Yes 2 W No To the Funeral Director. After this cerum. To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗷 No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🛱 Natural injury 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signat re and tile of certifier 29d. Date signed (Month, Day, Year) 00 Ausust 21, 2012 address of person who completed cause of death (Item 23a) (Type, Print) Drive, Rockaille, Mom Center Rost, 9901 Medical 31. Date filed (Manife, Bay Year) 2012 State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 17. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 102 reel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Min Director 1 🗆 M 2 🔀 F 3 6 arolina Page 1 and 2 should be filed within 72 hours after death with the iviaryiariu timent of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director andover 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 20185 USA reele 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) aretake Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Williams 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Domanic 20a. Method Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State erifa. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician.

To the Funeral Director: After this certificate has been signed by the attending physician. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number -0032761 0 .9470-Anna Polis Rd. #418 Lanham 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

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32. Registrar's Signature

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 17, 2012 4:50 p м James Frances Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Burnett-Calvert Hospice House** Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours May 8, 1924 Country) Director 88 213-40-9385 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9516 Southern Maryland Blvd 20754 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 No Specify. 3 - Widowed 4 - Divorced Specify: Completed Year or Dates. Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Foreman Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I **Edward Wood** Minnie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9516 Southern Maryland Blvd Dunkirk, MD 20754 if Health airem 27 i Sarah Johnson - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery August 23, 2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee Gladen 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death detached Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PARKINSONS DISEASE, DIABETES 1 Yes 2 No 3 Probably Unknown Completed ABDOMINAL MASS 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law nas autops prior to completion of cause of death? page 24 hours after death. Funeral Director: After this certificate 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE HOUSE Hospital Other: 1 ☐ Yes 2 →No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

AUG 20 2012

30. Name and address of person who completed cause of death tem 23a) (Type, Print)

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32. Registrar's Signature

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8/20/2012 PRINCE FREDERICK, 40

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Physicia		egistrar . Decedent's Name (First, Middle,Last)				2. Date of D	eath Dav	Year		e of Death				
M∘dical Examir	ег	Jessica L. Johnston					28, 2012			00 hrs				
		la. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital		4b. City, Town, or Rockville	Location of I	Death		ounty of Dea	itn					
			yrs. last birthday)	If Under 1 Yea	r If Under 2	24Hrs. 8. Date of	Birth (MM/DD		lirthplace	(State or				
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rs afte	<u>≥</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decede	nt's Usual Decupa	tion (Give kir	nd of work done		d of Busines	s/Industry					
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5-0 led w Hygie		17. Father's Name (First, Middle, Last)				Name (First, Middl Jean M.	e, Maiden Su Hagg	<sub>rname)</sub> enmake	er					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	B	Joshua A. Johnston  19a. Informant's Name/Relationship (Type, Print)	19h Mailin	a Address /Stree		er or Rural Route I				ode 208/4				
MD 2 d 2 should Ith and M n 27 is m numatic	-1	Jean M. Johnston - Mother	129	06 Poppy	Seed	Court, G	ermant	own, l	Mary	Land				
and 2 and 2 (ealth traum	ł	20a. Method of Disposition	20b. Place of Dispo	sition (Name of ce		Date	20c. Lo	cation - City	or Town,	State				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must he notified at once.		1 Burial 2 Cremation 3 Removal from State	crematory or o Metropoli	<sub>tnerplace)</sub> tan Crem	atori	ım 9/2/12	Alex	andri	a, Vi	irginia				
ltin. Paratmer artmer ortan	ŀ	4 Penation 5 Other Specify: 21. Signature of Funeral Service Licensee				lams P.A.		ral H	OTTLE					
Ban perm Perm Depic		Loveri L. Hilliam	26	401 Ridg	e Road	i. Damas	cus, M	lary1a:	nd 4	20872				
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter	the mode of dying	, such as car	diac or respiratory	arrest, shock	, or heart		roximate Interval ween Onset and				
/Medical Examiner		Immediate Cause (Final disease a. Sepsis	ė i						-	Death				
) Examino.	- 1	Due to (or as a consequence of): Beta hemolytic Streptococcus Group B infection of cerebral spinal fluid and early Pneumonia												
	<b>a</b>	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque		DP III -										
	튑	cause. Enter Underlying Cause (Disease or injury that initiated control to the co	anno of):											
recuted 1 and - transit	Exa	events resulting in death) Last Due to (or as a conseque d.	silce or).											
8 2 3	ical Examiner	▼ UNPENDED	,27,per m	e,g935 1	-9-13	sm	_							
		IF FEMALE: 23c. If yes, outcome of	of pregnancy					Date of deliv						
Box 68760, e death certificate but the attending physic ed for use as the but	Physician/Mec	23b. Was decedent pregnant in the past 12 months?	n of dooth	etal death 3	Ectopic	pregnancy	- N	Ionth	Day	Year				
OX eath c atten for us	/sic	1 Yes 2 No 9 Unknown 9 Unknown	e or death 5 [ ] (	ther (Specify)										
tal Records, P.O. Box cian: The law requires that the deatl certificate has been signed by the att ector, page 2 should be detached for		Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause	given in Par					use of death?				
P.C.	E S					1	Yes 2	No 3 P	robably	4 V Unknown				
rds requi	Completed						utopsy	prior t	o comple	findings available tion of cause of				
eco ne law tte has	m d						erformed? es 2 No	death 1		2 No				
II Rous: The Triffica tor, pa	0	25. Was case referred to medical		26.Plac	e of Death (	Check only one)								
Division of Vital Records, P.O. at or attending Physician: The law requires that it rafter death.  **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	To B	examiner? 1 ✓ Yes 2 No Ho spital: 1 Inpatient	2 🗸 ER/Outpatie			Nursing Home 5			her:					
ing Physi After this		27. Manner of Death 1 X Natural 5 Paneling 28a. Date of Injury (Month, Day,Year)	28b. Time of	· · ·   -	ury at Work?		ibe how injur	y occurred						
tendi tendi death ctor: y the f	atio	2 Accident Investigation			Yes 2		n (Street an	d Number or	Rural Ro	ute Number, City				
Divisior pital or Attent cours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	- At home, farm, str	eet, ractory, onice	building, etc		m, State)	a Number of	T(d) d) T(O)	ate Hambon, only				
E 6 6 5		4 Homicide  29a. Certifier A Code in a Physician: To the best of my kn	nowledge death occ	urred at the time	date and plac	ce, and due to the	cause(s) and	manner as s	tated					
To the Hos within 24 h To the Fur completely	ical	one) 2 Medical Examiner: On the basis of examin	ation and/or investig	ation, in my opinio	n, death occ	urred at the time, o	late and plac	e, and due to	the caus	se(s)				
To To Com	Medical	29b. Signature and title of certifier		29c, Licer	se number	<del></del> -	29d. D	ate signed (	Month, Da	ay, Year)				
		10 d. 11K" or TA		0.0	.M.E.	OGME	Augu	st 29, 20	12					
		30. Name and address of person who completed cause of deat	th (Item 23a)											
					0.1	at Daltimann	MD 2422	2						
		Thendore M. King, Jr., MD. Assistant Med	lical Examiner	900 W. Balti	more Stre	et, baitimbre,	1010 2122	J						
S Regis	tate			900 W. Balti	more Stre	et, Baltimbre,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUQUST Raymond Calvin Kell 1530 17 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Taibot 9.aston MEMORIAL HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Days Hours 185-28-8087 77 Director 1 X M 2 □ F April 18,1935 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at death with the Maryland Director Dorchester MD Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 226 Market Square 21613 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give Year or Dates white Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) pleasure boat salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garrett Kell Virginia Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane A. Kell wife 226 Market Square, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Crematory of Delmarva: 8/21/12 4 ☐ Donation 5 ☐ Other (Specify) Delmar. DE ture of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signa 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) C-6 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-transit e Hospital or Attending Physician: The law requires that the death certificate be executed 2.24 hours after death.

2.4 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician and sietely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Nnknown Fibrillatio 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Dempatient 2 ER/Outpatient 3 DOA မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10093110

Registrar
DHMH 17 Rev 06-2011

State

Raymond

Kell,

219 S. Washington St., Easton, MD

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Dennis DeShields M.D.

AUG 22 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dorothea Rogers Kingsbury Physician/ August  $18^{\text{Day}}$  2012 11:50 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert 2640 Beaver Dam Road Chesapeake Beach 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 353-18-8301 **Director** 1 M 2 X 1 03/25/1925 Indiana 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No Calvert Chesapeake Beach 10e. Street and Numbe 10g. Citizen of What Country? "natural", or items 23a Funeral 2640 Beaver Dam Road 20732 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Archie Mootie Rogers Eleanor Mayree Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau once. Donna L. McNally, daughter 2640 Beaver Dam Rd., Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 08/23/2012 | Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. Bliange M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician. alcha disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) 1 ☐ Live Birth 4 ☐ Pregnant : 9 ☐ Unknown in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' 1 Yes 2 No 1 Yes 2 completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director; After Investigation Acciden 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to the cause(s) and manner stated to the cause (s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address

State Registrar

AUG 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician/ 12:42 A<sup>M</sup> Inza Faye Koons August Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Autumn Assisted Living Hagerstown 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 □ M 2 🗷 F July 22, 1930 Arkansas 82 511-24-2122 **Director** Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21740 310 Cameo Drive 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes Give Specify: White "natural", 3 Divorced Completed Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Jewelry Sales Clerk 12 th Be 18. Mother's Name (First, Middle, Maiden Surname) if. Page 1 and 2 shou.

out of Health and Menta.

'on 27 is marked of 17. Father's Name (First, Middle, Last) Naomi Emiline Hobbs <u>John Edward Ter</u>ry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1585 Waltz Road, Big Cove Tannery, PA 17212 <u>Terri L. Narron / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 and Department of H Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Hagerstown, MD Rose Hill Cemetery 09/01/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 North Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DEMENTU Physician EN0 STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) < Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last ending physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atten for us in the past 12 months? Pregnant at time of death g Unknown the 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò MTCER 72 ~5100 1 Yes 2 No 3 Probably 4 Unknown DIAGETES MALLITUS Completed 24b. Were autopsy findings available MY COLLICIDEMIA 24a. Was an prior to completion of cause of death? has performed 1 ☐ Yes 2 ☐ No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be AUTUMP ASSISTED examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 2012 D0014019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HACERSTOWN MA 21740 340 Mill DATTA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Lee, Jr. Edward Newton August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number **Funeral** (Month, Day, Year) Hours 218-34-6988 1 X M 2 D F **Director** 83 Yrs. 03/29/1929 Maryland Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 No Mechanicsville St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe ms 23a or must be n USA Funeral 20659 26890 Three Notch Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner and any injury or other traumatic event, the Medical Examiner once. Black, White, etc. Yes 2 No þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Saw Mill **Operator** 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Marie Curry 2 Edward Newton Lee, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 39707 Sunnyside Road Clements, MD 20624 Marjorie G. Spalding/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 08/27/2012 | Mechanicsville, MD Mt. Zion Methodist 4 Donation 5 Other (Specify) 22. Name and Matting Tey-Gardiner Funeral Home, P.A. Tagardtown, MD 20650 21. Signature of Funeral Service Licens 41590 Fenwick Street Leonardtown, MD uchaely Ø arouner 23a. Par 1. Enter the disease, or cominications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Depression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Renal Failure use as the burial-trar that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months? Yes 2 No g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Yes 2 🗙 No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Other: 1 Yes 2 X No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work?
1 Yes 2 No 1 X Natural 5 Pending . vatural
Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29c. License number 29b. Signature and title of ce 08/22/2012 D070900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

AUG 2 7 2012

Kirandeep Kaur

6934 Aviation Blvd., Glen Burnie, MD 21061

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Gregory 2 2012 Longacre Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22611 FDR Blvd Lexington Park . Mary' 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Hours (Month, Day, Year Country Director 195-30-3552 1 **X**) M 2 □ F 72 04/17/1940 Pennsylvania should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "nature!", or Items 23e or 28a-f show aumatic event, the Medical Everning must be not fled at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Lexington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 22611 FDR Blvd 20653 United 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. ģ 1 Never Married 2 Narried Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Automotive Supply</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ည Frederick Longacre oletta McCavitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Longacre/Wife FDR Blvd, Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 08/25/2012 Charlotte Hall, MD 21. Signature of Buneral Service Licenses
Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ease or condition Medical resulting in death) Due to (or as a consequence ≟xaminer Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physicien: The lew requires thet the death certificate be executed ate has been signed by the attending physiclan and page 2 should be detached for use es the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{X} \text{ Residence} \) 6 \( \text{Other} \) Other (Specify) 2 NO Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person, Jennifer Schmidt D. 0 40900 Merchants Lane. Suite 205. Leonardrown MD 20650 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

			1 - State Registrar	State of Ivialyia	•	rtificate of		, 0	leg. No. 201	2 20750
	Physici	an	1. Decedent's Name (First, Middle, Last)  CATHRYNE M.	LANKFORD				2. Date of Dear Month	Day Ye	
	/Medic Examir		4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Death	August	20, 2012 4c. County of D	
d	LAdiiii	CI	Alice Byrd Tawes N	ursing Home		Crisf	ield		Somer	set
2	Funeral Director		220-16-9363	7. Age (In yrs M 2対F 86	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 02/02/1	y, Year) 9.	Birthplace (State or Foreign Country) aryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	e Maryla 8a-f sho etified at	ctor	Maryland Somerset		Mario	on Static	on			1 □ Yes ¾□ No
	th with the 23a or 2 ust be no	<b>Funeral Director</b>	10e. Street and Number 5882 Crisfield Hig	hway		10f. Zip Code	1838	1	I0g. Citizen of What	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify: W.	American Indian, Vhite, etc. hite
21215-0036	hin 72 ho e, In "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		ı (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Busine	ess/Industry
21	d with giene gr tha	اق ق	12		Homema	aker			Own Home	
Maryland	lld be file lental Hy <b>ked othe</b> ic event	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  John H. McGrath				18. Mother's Name Addie Ma		Maiden Surname)	
ary	shou and M s mar		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Numbe	r, City or Town, Sta	te, Zip Code)
	and 2		Robin Twilley Karen Kitching (Dau	ghters)			treet - C	risfield	d, MD 218	17
ore	of He of He f Item		20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ Re	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
<u>Ĕ</u>	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Specify)	St	. Paul	's Cemete	ry 08/24	/2012	Marion S	tation, MD
Baltimore,	permit. Depart Import any Inj		21. Signature 5 ner Service Service Service Robert H. Brads	haw. Ir.	Bi 30	2. Name and Addre Cadshaw & 06 W. Mai	ss of Facility Sons Fun n StCri	eral Hor sfield,	me MD 21817	
3			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ž	LS					Onset and Death
ŀ	/Medical		resulting in death)	Due to (or as a conse	equence of):					
ĥ	Examiner	Ļ	Sequentially list conditions, b.							
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (1999) that initiated events	Due to (or as a conse	equence of):					
_	xecut and I-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):					
68760,	tificate be executed ig physician and as the burial-transit	a E		`	,					
289	ificate g phy as the	ledical	0							
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 To No 9 ☐ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of Month	f delivery Day Year
٣.	that the		Part II. Other significant conditions con	tributing to death but not re	esulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
rds	quires an sigr uld be	ed by						1 □ Y	es 2 No 3	Probably 4 Unknown
Division or Vital Records,	e la has le 2	Completed							rm <u>ed?</u> dea:	re autopsy findings available r to completion of cause of th?
ital	10 14	Be	25. Was case referred to medical				26. Place of Deat		_	Yes 2□ No
>	rysici lis ce direc	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott	her: 4 Nursing Ho	ome 5 🗆 Resid	lence 6 Other (	Specify)
n 0	Attending Physician: r death. sctor: After this certification of the funeral director.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	ry at	28d. Describe h	now injury occurred	
sio	tendil eath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2□No			
Σ	in the	Certification:	4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (S City or Tow	Street and Number o vn, State)	or Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical Examir	ician: To the best of my k						
	thin 2 the I	Medical	one) 29b. Signature and title of certifier	and manner stated.						
	T W L		235. Signature and title of certifier		0	250. 21081	10-0102	'	917 -	(12
	AA		30. Name and address of person who co	mpleted cause of death (1)	em 22a) /Tura	Print)	45018			116
	12		Dr-Vigay	Kayumbur	attar	201	Hall Hi	Slesay	, (rufie	oll2.
	St Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 2 1 2	32. Registrar's Sig	nature	pares		V		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 21 Day Geraldine Hutchins Lankford 2012 8:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 625 Adelina Road Prince Frederick Calvert Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Hours 215-24-3306 **Director** 1 □ M 2 🗑 F 84 09/29/1927 Maryland Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Calvert Prince Frederick 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code r items 23a or ner must be n 10g, Citizen of What Country? Funeral 4855 Sandy Point Road 20678 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, iral", or iter þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Book Keeper Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Allen H. Hutchins Carrie V. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice L. Bowen / Daughter 625 Adelina Road, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Asbury Cemetery 08/27/2012 | Barstow, Maryland 22. Name and Address of Facility Rausch Funeral Home, PA 4405 Broomes Island Road, Port Republic, MD 21. Signature of Funeral Service Licensee Kyle S. Simons MO1286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician ANEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** GASTROINTESTINAL BLEEDING - CHRONIE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on -transit Cause (Disease or Injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a Physician/Medical requires that the death certificate be F FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached the g Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 6 X Other (Spe Daughter's 2 🔯 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after death.

he Funeral Director, After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician:

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he Hospi in 24 hou he Funer ipletely fil	Medica	(Check 2 Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, and due to the and/or investigation, in my opinion, death occurred at the time, date by knowledge, death occurred at the time, date and place, and due to	e and place, and due to the cause(s) and manner stated.
To th withir сотр		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		I ften Mul	D 40370	8/22/12
dew 10		30. Name and address of person who completed cause of death (Item : Perck WISWICKI, M)	23a) (Type, Print) 110 HOSPETAL Dr. SUTTE 310	PRINCE FRENCE, MINOR
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registral Signatu	ure B K	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Milton Delmer Lawyer 28, August 2012 5:45 Р Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood Williamsport Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-10-0137 1 M 2 □ F 94 Director June 19, Maryland ir than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City, Town or Location Director Md. Washington 1 X Yes 2 No Smi thsburg 10e. Street and Number 10g. Citizen of What Country? 7 W. Water St. P.O. Box 12 U.S.A 21783 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 A Yes 2 No If Yes, Give Year or Dates. 4 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 ☐ Divorced 41 - 4615. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner & Operator Auto Sales & Parts permit. Page 1 end 2 should be filed w De; entment of Health and Mental Hygi Im; ortent: If item 27 Is marked other any Injury or other traumetic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton O. Lawyer Mary E. Fike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian D. Lawyer (Son) 12617 Wolfsville Rd. Smithsburg, Md. 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Smithsburg, Md. 4 Donation 5 Other (Specify) Smithsburg Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that roused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Met and Death Physician/ MOFOUNG disease or conditi-resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires thet the death certificate be executed attending physician and for use as the burial-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day been signed by the s should be detached Part II. Other significant conditions contributing to the hour hour resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funerel Director: After to the funer completely filled in by the funer 1 Natural 2 Accident 5 Pending work? 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours at To the Funerel D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ed (Month, Day, Year) 100 2012 Intera (CAZ rover las 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 201<sup>Yea</sup> SAMUEL SHEEDY MOORE 18 6:55P Medical AUG 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 12321 CHERRY BRANCH DR. CLARKSBURG 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 M 2 D F Months Davs Hours 213-49-0925 1 2 9 1 4 7 1 9 9 6 15 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MONTGOMERY MD CLARKSBURG 10e Street and Number 10g. Citizen of What Country? 9 10f. Zip Code items 23a or ner must be n Funeral 12321 CHERRY BRANCH DR. 20871 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT **EDUCATION** 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Item 27 is marked any injury or other traumatin and ပ CAROL ANN KAMACHAITIS JOHN SHEEDY MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERRY BRANCH DR., JOHN S. MOORE / FATHER CLARKSBURG, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ST. MARY S 1 W Burial 2 Cremation 3 Removal from State BARNESVILLE, 08/24/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility P.O. HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PROGRESSIVE GLIOBLASTOMA MULTIFORME disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Accident Investigation completed filled in by the 6 Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NW WASHINGTON DC

Registrar DHMH 17 Fav 7/2009

State

111 MICHIGAN AVE.

MD

32. Registrar's Signature

Hiveing

Year)

AUG

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Aug. 18<sup>Day</sup>2012 0930A M Theodore Eugene Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Braddock Heights Vindobona Nursing Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Right Days (Month, Day, Year) 047-22-4390 96 Director 1 🛛 M 2 🗆 F Yrs Canada July 30, 191 6 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4833 Mount Zion Road 21703 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. X Yes 2 No World Yes, Give <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Specify: White Completed War II Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator and Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mark Chester Miller Alice Elenore Rickard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl Mark Miller / Son 4833 Mount Zion Road, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a Depertment of H Important: If Ite eny Injury or ot Cemetery, crematory or other place Mount Olivet Cemetery 1 🖾 Burial 2 🗀 Cremation 3 🗆 Removal from State August 24, 2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myo Corrdo disease or condition resulting in death) mintes Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury attending physician end for use as the burlel-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes funeral director, page 2 autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🕱 N Hospital or Attending Physicien: 25. Was case referred to medical of Vital B 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division To the Hospital or Attendin within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: on the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 8-21-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave JK) Frederick, MO 21701 laidi Mo House 108 Tou 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

A BELLAR

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Stephanie Leigh		1- For State	State of Mar		Departm				Hygiene	21	NI2 2876	-
Physicia	in/s	Registrar  1. Decedent's Name (First, M	iddle,Last)	_					2. Date of Dea		3. Time of Death	2
Medical Examir	_	Stephanie	Leigh Ma	rtin					Month August 27		0/44 nrs	
)	4	4a. Facility Name (if not instit 24699 Horseshoe F		d number)		44	City, Town, or Lo	ocation of Dea	th	4c. County of St. Mary		
Suggest		5. Social Security Number	6. Sex	7 Age (	In yrs. last bi	rthday)	If Under 1 Year	If Under 24H	rs I 8 Date of Rin		9. Birthplace (State or	_
Funeral Director							Months Days	Hours M	in	`	Foreign	1
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ku <b>a</b>	ŀ	10a. State 10b. Cour		10	c. City, Town	n or Locatio	n				10d. Inside City Limits	;
	٦	Maryland St.	Mary's		Clem	ents					1 Yes 2 X No	)
faryla 28a-f	ig ig	10e. Street and Number					10f. Zip Code		11	0g. Citizen of Wh	nat Country?	_
the N	Funeral Director	24699 Horses	hoe Road				20624			United	States	
ms 2.	era	11. Marital Status	12. Was	Decedent Ev	er in U.S.	13. Was	Decedent of Hispa s, specify Cuban, I	anic Origin? (	Specify Yes or No	- 14. Race White	- American Indian, Black,	
r death	딃	1 Never Married 2 X	1 Ye	s 2 🔀	₹ No				o recar, etc.)	VVIIICO	, 0.0.	
s after	2		Divorced If Yes, Give or Dates:		-td) [46-		es 2 X No Usual Occupatio		Lucali dono	Specify: 16b. Kind of Bus	White	_
hour matu	ted	15. Decedent's Education (S Elementary/Secondary (0-		e (1-4 or 5+)			t of working life. D			100. Aind of bus	siness/industry	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Mid	dle, Last)		<u> </u>	omema]	18	.Mother's Nan	ne (First, Middle, M	Own Ho Maiden Surname)		-
215 be file ntal H	å	John Rober	t Herrin	gton				Eleano	r Ann	Goldson		
21 hould 1 hould 1 is man	2	19a. Informant's Name/Relation	onship (Type, Print )		19	b. Mailing /	Address (Street a	and Number or	Rural Route Num	ber, City or Town	n, State, Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Paul B. Mart	in, Sr./H	usband	1 :	25857	Bush Cou	irt, Me	chanicsv	ville, M	D 20659 City or Town, State	_
ore, sla of He of He		20a. Method of Disposition  1 Burial 2 X Crema	tion 3 Remov	al from State		of Dispositi	on (Name of ceme r place)	itery,	Date	20c. Location -	City or Town, State	
Page ment tant:		4 Donation 5 Other	Specify:			field	-Echols (	Cre 08/	31/2012	Charlo	tte Hall, MD	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Sep	ice Licensee						THOTTCIC	I dilet d	i mome, i ili	
	$\dashv$	Edward N. Bri 23a. Part I. Enter the disease	nsfield.	Jr.MO	0052	229	mode of dving si	wood R	oad, Leo	nardtow	n MD 20650  Approximate Interval	_
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Box 68760, e death certificate be the attending physic the attending physic ed for use as the burned	We	IF FEMALE:	a the		of pregnancy	,		1		23d. Date of	delivery	1
68 certifi nding se as 1	jan	23b. Was decedent pregnant i past 12 months?	'	e birth egnant at tim	a of doods		death 3	Ectopic pregr	nancy	Month	Day Year	
30X death	Physician/Me	1 Yes 2 No 9	Inknown I	known		⊃ Othe	r (Specify)			1		ď
P.O. B. that the de ned by the detached i		Part II. Other significant con	ditions contributir	g to death b	ut not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?	٦
signe	و و								1 Yes	2 No 3	Probably 4 🗸 Unknown	
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ecc he lav ate has	Ē								perfor	med? de	eath? ✓ Yes 2 No	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to med	ical	_			26.Place of	Death (Check	only one)			_
Vita		examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient	2 ER/C	Outpatient	3 DOA	her <sub>4</sub> Nurs	ing Home 5	Residence 6	Other: Scene	
ing Ph		27, Manner of Death  1 X Natural 5 D	28a. D (M	ate of Injury onth, Day,Year	28b.	Time of Inju			28d. Describe h	ow injury occurre	d	
ttend ttend death. ctor:	atio	= 3LJP	ending vestigation				1 Ye:					
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  It Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	Certification	d	ould not be 28e Fetermined (Spec		y - At home, f	farm, street,	factory, office buil	ding, etc.	28f. Location (S or Town, St		er or Rural Route Number, City	
Di c Hospital		4 Homicide	Physician: To the	-	nowledge, de	ath occurre	d at the time, date	and place, an	d due to the cause	e(s) and manner	as stated.	+
To the within To the complet	Medical	one) 2 Medical E	xaminer: On the ba and mann		ation and/or	investigatio	n, in my opinion, d	eath occurred	at the time, date a	and place, and du	ue to the cause(s)	
	Ž	29b. Signature and title of cer	tifier	1/	1		29c. License r				ed (Month, Day, Year)	
		ull		10	B		O.C.M.	E.		August 28,	2012	
NO-		<ol> <li>Name and address of personal Zabiullah Ali, M.D.</li> </ol>	Assistant Me		. ,	) W. Ba	itimore Street	, Baltimore	, MD 21223			
Sta		31. Date filed (Month, Day, Ye	ar) 32	Pogistror's	Signatura							+
Registi	ar	SEP 0 4 2	017 /	m ,	d.	- Comment						- 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Ida Virginia Mister 2012 10:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day, You April 8 Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** <sup>(ea</sup>1923 Maryland 89 Director 1 M 2 X F 213-98-7459 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Ħ Director notified 1 🗆 Yes 2 🏝 No 28a-f Broomes Island Maryland Calvert 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be n 20615 Funeral United States 8510 Church Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item edical Examiner r 14. Race - American Indian 11. Marital Status Armed Forces White, etc. þ 1 Never Married 2 Married 2 XIO permit. Page 1 and 2 should be filed within 72 hours after Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 T Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosy Marie Smith ပ္ Moody L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Gode) 8510 Church Road Broomes Island, MD 20615 Martin W. Mister, Sr. - son 20a. Method of Disposition Augus Dat 23 20 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Broomes Island MD Broomes Island Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic, MD 20615 (Dund) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final Physician/ oca disease or condition resulting in death) Medical Examiner Someonifelia list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No page 2 should be detached for Day Month Year þ Other significant conditions cor 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Chronic perform within 24 hours after death.

To the Funeral Director: After this certificate be completely filled in by the funeral director, page To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 X Inpatient 2 🗆 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Bractifioner: To the best of poly nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rose Louese May		1- For State Registrar	Sta	ate of Maryla	•	artment o		d Mental H		Reg. No. 20	12 2876
Physician	n/	1. Decedent's Name					<del></del> -		2, Date of Dea	ath Day Year	3. Time of Death
Medical Examin	er	ROSE  4a. Facility Name (if	Loues		imber)		4b. City, Town, or L	ocation of Deat	August 2	1, 2012 4c. County of I	0602 hrs
		500 Main St		i, give stieet and ni	imber)	ŀ	Ellicott City	Location of Deat	"	Howard	Jeani
Funeral	7	5. Social Security N	umber	6. <b>S</b> ex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of B		9. Birthplace (State or
Director	-	216-37-4	439	1 M 2X F	1	9 Yrs	Months Days	Hours Mir	11/05		Foreign Country) MD
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vith th		11. Marital Status	TOLECT I		cedent Ever in U	J.S. 13 Wa	s Decedent of Hisp		pecify Yes or No		American Indian, Black,
eath v	Funeral	1 X Never Marrie	ed 2 Ma				es, specify Cuban,			White,	
after d	<u>~</u> _	3 Widowed	4 Divo	or Dates		1	Yes 2X No	specify:		Specify:	White
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36 in 72 l		Elementary/Seco	ndary (0-12)	College (							
with a with giene ther there	Completed	17. Father's Name (	First, Middle.	Last)			Studer		e (First. Middle.	Educ Maiden Surname)	cation
21215-0036 uld be filed within 7 Mental Hygiene c event, the Medica	9	Mark J		<b>,</b>					on L. F		
D 21215-00% should be filed within and Mental Hygiene. The marked other unatte event, the Med	┋┞	19a. Informant's Na			-	19b. Mailin	Address (Street			mber, City or Town,	State, Zip Code)
MOTE, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland Lenf of Health and Mental Hygiene. Int: If item 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	L	Mark J. I		Father		8227	Church La	ane Driv			7, MD 21043
Baltimore, ME permit. Pages 1 and 2 s. Important: friem 17 injury or other traums injury or other traums.	1	20a. Method of Disp		3 Removal fr		Place of Dispos crematory or ot	ition (Name of cem ner place)	etery,	Date	20c. Location - Ci	ty or Town, State
iment Page ment tant:		4 Donation 5	Other Spe	ecify:		mation	Center of	E MD 08/	25/12	Hanov	ver, MD
Ball Depart Impor	Ì	21 Signature of Fur	neral Service I	icensee	0	22. N	lame and Address	of Facility Har	ry H. W	litzke's F	Tamily FH Inc.
Physician	+	23a. Part I. Enter the	e disease, or o	complications that	nused the death					<u>licott Ci</u> rest, shock, or heart	ty, MD 21043 Approximate Interval
/Medical	1	failure. List onl	y one cause o				, ,				Between Onset and Death
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Division of Vital Records, P.O. Box 6876  Hospital or Attending Physician: The law requires that the death certificate  Hours after death.  Funeral Director: After this certificate has been signed by the attending phy  tely filled in by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 3b. Was decedent p		23c. If yes,	outcome of preg pirth		tal death 3	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
lox 6 leath cert e attendii		past 12 months			ant at time of de	ooth -	her (Specify)		-		
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tal Recian: The certificate ector, page		75 Man	- d to	_			00 81	- ( D 1) ( O 1)	1 ✓ Yes	2 No 1 🗸	Yes 2 No
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be attended.	ן מ	25. Was case referrence examiner?		Hospital:	Inpatient 2	ER/Outpatient		of Death (Check		Residence 6 🗸	Other: Scene
of Ving Physical After this uneral direction		1 ✓ Yes 2 27. Manner of Death	No No	28a Date	of Injury	28b. Time of I		at Work?	28d. Describe	how injury occurred	
ision of Attending Ph ar death. ector: After t by the funeral		1 Natural 2 Accident	5 Pendi	19 A 04	Day,Year)	FOUND: 0030 hrs	1 Y	as 2 🗸 No	Train deraile of subject	ed with its coal	car overturned on top
or Att frer de in by	<u> </u>	2 Accident 3 Suicide		igation			et, factory, office bu	ilding, etc.			or Rural Route Number, City
Divis  Hospital or A 24 hours after Funeral Dire tely filled in b	Certification:	4 Homicide	deterr	nined (Specify)	Train Bridg	ge			500 Main Str	eet, Ellicott City, M	1D
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To the He within 24 To the Fu Completely	9	29b. Signature and		and manner s			29c. License		at the time, date		(Month, Day, Year)
		1/		w's			O.C.M			August 21, 20	
	-	30. Name and addre	ess of person	who completed caus	se of death (Item	n 23a)				J	
3		Ling Li, MD		it Medical Exar			e Street, Baltir	more, MD 21	1223		
Stat	е	31. Date filed (Monti	Parties)		istrar's Signat	ure & /	- 41				
Registra	: 17		TUU ~ (	1 LUIL /	Crewa	CI. LBI	IL/Ce				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AUGUST 8:15 Shirley Fout Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Meritus Medical Center Hagerstown 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 214-32-4636 Director 1 □ M 2 🛛 F Nov. 28,1925 86 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director Maryland Washington County Hagerstown Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 1147 Oak Hill Ave. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Interior Design Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hollis S. Fout Margaret Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly H. Miller-daughter 126 Thornton Rd. Thornton, PA 19373 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or Smithsburg Crematory 8-19-2012 Smithsburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Onset and Death Immediate Cause (Final Physician/ GASTRO INTESTINAL DAY BLEEDIN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EL BRULLTION CHURATRIAL Se uentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed POSSIBLE 10 Low resty FOW Hours this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical ESPINATORY Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: s after death. I Director: After t 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined hours a within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the policies at the sine state at the sine stat 5 29b. Signature and title of certifler 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 26 Day Physician/ Month 08 2012 9:05 A M Dona1d Harvey Nolan, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 30133 Shoreview Drive Mechanicsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **Director** 579-22-0040 1 X M 2 🗆 F 87 01/18/1925 Washington, DC Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's Mechanicsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20659 30133 Shoreview Drive USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc ρ 1 Never Married 2X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Vice President - 1UOE Local 77 Operating Engineer 77 Union of Local Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygier. 12 Operating Engineers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marie Frances Lipphard Robert Elmer Nolan traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau B0133 Shoreview Drive Mechanicsville, MD 20659 Grace Nolan / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Washington National Cem 9/1/12 Suitland, Maryland 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Alzheimers Disease years Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician use as the buris Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed Yes 2X certificate 2X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛚 No Other: 4  $\square$  Nursing Home 5X Residence 6  $\square$  Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of Certificate: 28d. Describe how injury occurred After 5  $\square$  Pending 1 X Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature d title of sertifier

Registrar DHMH 17 Rev 06-2011 USWIN SMUTH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Charles M. Benner, M.D.

AUG 2 9 2012

29c. License number

20945 Great Mills Road Lexington Park, MD 20653

D31563

29d. Date signed (Month, Day, Year)

August 28, 2012

12-06294 Elizabeth Conw	ay N				n Black In and / Depa							egib	_	ור	2 287
		1- For State Registrar			Ce	rtificate of	Dea	th				Reg. N		J 1	2 201
Physici	an/	1. Decedent's Name (First	, Middle,L	ast)						1	2. Date of D	eath			3. Time of Death
Medical Exami	iner										Month August 2	21, 20	Year		0553 hrs
		4a. Facility Name (if not in 500 Main Street	stitution, g	ive street and n	umber)			Town, or lott City	Location	of Death			4c. County o Howard	Death	
Funeral		5. Social Security Number	6.	Sex	7. Age (In yrs. I	ast birthday)	If Und	der 1 Year	If Und	er 24Hrs.	8. Date of I	Birth (MI	W/DD/YYYY)	9. Birl	hplace (State or
Director		401-45-6483		M 2X F	19	Yrs.	Mont	hs Days	Hour	Min.	10/2			Foreig	n untry) KY
any		Usual Residence of Deced 10a. State 10b. C			10c City	Town or Location	on					-			10d. Inside City Limit
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vith the Maryland 123a or 28a-f show notified at once.	Director	2605 Sara	Beth	Court			101. 21	2104	12				itizen of Wha Inited		•
ms 2	era	11. Marital Status			cedent Ever in U.						cify Yes or N		14. Race -	Americ	can Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hems 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 Never Married 2 3 Widowed 4		1 Yes	2 X No			ity Cuban,		, Puerto R	ican, etc.)		White,		ite
ours a	d by	15. Decedent's Education	(Specify	or Dates: only highest gra	de completed)	16a. Decedent	's Usua	Occupation	on (Give	kind of wo	rk done	16b.	Kind of Bus		
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Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funeral S	ervice Lice	ensee								Witz	zke's	Fam	ily FH Inc
<b>©</b> age ig		Juanta 100	9	)2000.											, MD 21043
Physician		23a Part I. Enter the disea	se, or com	plications that c	aused the death.	Do not enter the	e mode	of dying, s	such as c	ardiac or r	espiratory a	rrest, sh	ock, or hear	į i	Approximate Interva Between Onset and
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68 Sertifi Iding	ä	23b. Was decedent pregnar past 12 months?	it in the	1 Live b	irth ant at time of dea		al death	3	Ectopic	pregnanc	у		Month	Da	ay Year
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the d	된	Part II. Other significant c	onditions		death but not re	sulting in the un	derivino	cause div	ven in Pa	rt I	23e. Did	tobacco	use contribu	ite to th	ne cause of death?
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Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as fact death.  al Director: After this certificate has been signed by the attending physicited in by the funeral director, page 2 should be detached for use as the burn	Completed										24a. Was				opsy findings available
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Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physic I Examine	lan: To the best r:On the basis of and manner si	t of my knowledg of examination an	e, death occurre d/or investigatio	ed at the en, in my	time, date opinion, o	e and pla death occ	ce, and du curred at th	e to the cau e time, date	ise(s) ar e and pla	nd manner as ace, and due	stated to the	l. cause(s)
ENER	Me	29b. Signature and title of c	ertifier	and mailled S			290	. License	number			29d.	Date signed	(Mont	h, Day, Year)
		hin 6	٠٠.					O.C.M	.E.			Aug	gust 21, 2	012	
	ŀ	30. Name and address of pe	erson who	completed caus	e of death (Item ;	23a)									
5		Ling Li, MD Ass				,	Stree	t. Baltin	npre. N	MD 2122	3				

State Registrar

31. Date filed (Month AUG 23 2012

		For	S	tate of Maryla	and / Depa	rtmen	t of He	alth and I	Mental Hy	giene ,	2012	28770
		State Registrar			Cert	tificate	of De	ath		Reg. No.	2012	. 20110
Physicia	n/	Decedent's Name (First, Manager)	,						2. Date of De Month	ath Day	Year	3. Time of Death
Medic	al	Rina There				4b City 3	Faum arla	ocation of Death	08	17	2012	
Examin	er	Calvert Memo		,				Freder			ounty of Deat Calver	
Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under	1 Year If	f Under 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign
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ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Mic	ldle, Last)				18	8. Mother's Nan	ne (First, Middle,	Maiden Su	rname)	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crema 4 Donation 5 DO		oval from State	cemetery, crem	atory or ot	her place)	09/0	5/2012		rlingto	
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Jing Ph n. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ P	Pending 2	8a. Date of injury (Month, Day, Year,	28b. Time of injury	28	c. Injury at work?	t	28d. Describe I	ow injury o	ccurred	
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or At after of Direct in by	Cert		etermined 25	8e. Place of Injury - A building, etc. (Spe		et, factory,	office		28f. Location (8 City or Tov		Number or Rui	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Cert	ifying Physician	: To the best of my kn	owledge, death of	ccurred at	the time. d	late and place.	and due to the ca	ause(s) and	manner as st	ated.
ne Ho n 24 } ne Fur	Medical	(Check 2 Med	ical Examiner: 0		ation and/or investi	gation, in n	ny opinion,	death occurred	at the time, date a	and place, a	nd <b>d</b> ue to the d	cause(s) and manner stated
To the Within To the Conf.		29b. Signature and title of ce	ertifier				License nu			29d. Date	signed (Month	
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DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Osmer Physician/ Elsie August 20 Day 2012 Yea 12:26 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Vindobona Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country). Florida Social Security Number 7. Age (In vrs. last birthday) Funeral 8. Date of Birth March 22, 1926 Days Hours Min. Director 013-24-2543 1 🗆 M 2 💢 F 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. 3 other than "natural", or items 23a or 28a-f sho 28a-f shov 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6012 Jefferson Boulevard 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Fashion Model Clothing Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Levi Motes Simonetti Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Gapland Road, Gapland, Maryland 21779 Sally Baker / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20a. Method of Disposition 20c. Location - City or Town, State August 21. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lig <sup>22</sup>Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 m M01473 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death EME Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) detached 9 🗍 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and tipe of certifier 29c. License number 12064223 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERILE, MD21702 HOLAN EEM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

12-06066 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Dolores Little Pennington** State of Maryland / Department of Health and Mental Hygiene 2012 28772 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 13, 2012 Dolores Little Pennington 1357 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 1532 Overlook Drive St. Leonard 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) PA Months Days Hours Min. 11/06/1940 Director 178-32-4840 2 XF 1 M Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits St. Leonard Calvert MD 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1532 Overlook Drive 20685 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2X No Yes White f Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Little Vera E. McCullough Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 19a, Informant's Name/Relationship (Type, Print) Craig Pennington(stepson) 1626 South Street, Key West, FL 33040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Buriat 2 X Cremation 3 Removal from State 08/20/2012 Clinton, MD Baltimo
permit. Page
Department of
Important: mportant: ijury or oth Lee Crematory Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Europeal Service Lice 8200 Jennifer Lane, Owings, MD 20736 Mounts Lisa M. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Elospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ca attending physician a for use as the burial -UNPENDED AMENDED Physician/Medi Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification 1 V Natural Division 1 Yes 2 No Pending the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Doy, Year) 12 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per FH C931 9/11/2012 JH State of Maryland / Department of Health and Mental Hygiene 1- State AMEND 29D, PER MD G931 9/20/12 TRT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year **Physician** Michael Joseph Palko, Jr. August 15, /Medical 12:55 P<sup>M</sup> 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Burnett - Calvert Hospice House Prince Frederick Calvert 5. Social Security Number 241 **Funeral** 6 Se 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑** M 2□ F 168 - 32 - 2Director 72 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3009 Ashwood Drive 20754 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1958–61 1 ☐ Never Married 2 X Married þ 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supervisor, photography lab U.S. Government, FBI 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Michael Joseph ည Palko, Sr. Catherine Potochny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Palko, wife 3009 Ashwood Drive, Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) / MD Veterans Cemetery | 08/21/2012 | Crownsville, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. wure of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic prostate cancer /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Library Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSDICE ပ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and | FZIG Callet Co. Division of Vital Records, P.O. Box 68760, signed by the attending physician has certificate this

28a-f show

event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0036

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State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and

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d cause of death (Item 23a) (Type, Print)

Merrimac C.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 5:52 AM 2012 Warren Palmer /Medical 4a Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death navenuced utheran Village Washington Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Hours 217-28-5826 Director Mar. 6, 1933 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exeminant injust be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Plantation Drive 21740 Funeral U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married à 1 ☐ Yes 2 X No 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver/Salesman Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Luther Edward Palmer Della Mae Tabler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Hershberger/Daughter 170 Stallion Court, Hedgesville, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 8/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compilations that caused the shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardioros adon disease or condition Hetero. mins resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 255 No 2 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To After this 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation To the Hospital or Attending, within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral or the funeral 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (i 2 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar nills

street Heigestorium 17021740

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Registrar's Signature

12-06425 Oscar Pedrozo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 28775

JOCAL I CUIOZO		1-For State Certificate of Death Registrar		eg. No.	2011
Physici Medical Exami		Decedent's Name (First, Middle,Last)	2. Date of Deat	th	3. Time of Death 2116 hrs
wedical Exami	mer	Oscar Arturo Pedrozo  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month August 25	, 2012 4c. County of Deatl	
		Holy Cross Hospital Silver Spring		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	_	th (MM/DD/YYYY) 9. Bir Foreig	
Director		229-25-5099 1 XM 2 F 3/ Yrs.	Nov. 1	, 1974 Was	hington, DC
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	F	MD Montgomery Silver Spring			1 Yes 2 No
Maryla 28a-f d at o	Director	10e, Street and Number 10f. Zip Code	10	og. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho	ral Di	9609 Braddock Road 20903		USA	
ath wi	Funera	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1912 If Yes, specify Cuban, Mexican, Puerto I		14. Race - Amer White, etc.	ican Indian, Black,
fter de l'', or		1 X Yes 2 No 1946 3 Widowed 4 Divorced If Yes, Give Year Gulf War 1 Yes 2 No specify: Para	iguayan	Specify: Whi	te
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retire		16b. Kind of Business/	•
5-0036 led within 72 hou Hygiene. lother than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Police Officer		Metropolit Police Dep	
d with	Com	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M		
21215-0036 ould be filed within 7 I Mantal Hygiene, i marked other than ic event, the Medica	Be	Florentin Pedrozo Candida	E. Cal	oallero	
O & B is is	T <sub>o</sub>	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Relationship (Type, Print)			
d 2 Mark		Lorena Pedrozo/Wife 9609 Braddock Road, Si  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	lver Sr	20c. Location - City or	0903 Town, State
imore Pages 1 nent of H		1 XXBurial 2 Cremation 3 Removal from State crematory or other place)  Au  Au  Donation 5 Other Specific  Gate of Heaven Cemetery	g. 31, 2012	Silver Spr	de Mi
Baltimore, permit. Pages l ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Date of Fine and Address of Facility  21. Signature of Funeral Service Licensee Francis J. Collins		Jiver spi	Ing, MD
		Lenence of Market 500 University Blyd	. W S	ilver Sprin	o MD 20901
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Sepsis due to Cholecystitis  Due to (or as a consequence of):			Death
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7	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated co			
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
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certification and ing	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnan	су	Month D	ay Year
Box 687  e death certific  the attending p  ed for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate that be after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 ✓ No 3 Prob	
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Division of Vital Records, tal or Attendiog Physician: The law requirers after death.  al Director: After this certificate has been side in by the funeral director, page 2 should be a page 3 should be a		25. Was case referred to medical 26.Place of Death (Check or	1 Yes 2	No 1 ✓ Yes	2 No
Vita lysician this cer direct	To Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2  ER/Outpatient 3 DOA  Other Nursing		tesidence 6 Other:	
liog Ph	٦	1 X Notice (Month, Day, Year)	28d. Describe ho	ow injury occurred	
Sion Attence r death ector: by the	Catio	2 Accident Investigation	Of Leasties (Ct	reet and Number or Run	al Pouto Number City
DIVI spital or nours afte acral Dir filled in	Certification:	Suicide  6 Could not be determined  (Specify)	or Town, Sta		al Route Number, City
Hosp 24 hou Fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and d			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Mon. August 26, 2012	th, Day, Year)
ZJM	-	30. Name and address of person who completed cause of death (Item 23a)			
,		Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	e, MD 21223	3	
Sta Registi		31. Date filed (Month, Day, Year)  3. Registrar's Signature			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28776 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year August 14, Katherine Patton Medical 1:32 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 8903 Merrill Lane # 201 Laurel Prince George's Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Months Hours **Director** 579-52-9941 1 □ M 2 🏲 F Yrs Jan. 29, 1941 Usual Residence of Decedent DC 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8903 Merrill Lane # 201 20708 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify **Black** 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry nould be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Health Aide Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie Wigfall Sr. Mattie Mae Johnson should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 8903 Merrill Lane # 201 Laurel, Maryland 20708 Sheri L. Jackson - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Crematory 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewart 1-M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cancer Metastatic To Brain 6 months Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Unknown Primary Cancer Examine Due to (or as a consequence of) that the death certificate be executed burial-1 resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Day Month Year be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 X No the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Hospital: မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death.

Director: Af 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 23, 2012

Registrar

DHMH 17 Rev 06-2011

Temple Hills, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6104 Old Branch Avenue

32. Registrar's Signature

Eunice Shakir

AUG 2 4 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 2. Date of Death Month 3. Time of Death Day Redden

Phys. Me Exa

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attending physician and

Division of Vital Records, P.O. Box 68760

drw Registrar

Medic	cal	Hargare								<u>  August</u>	<u> 19,</u>	2012	<u> 7:</u>	30 A M
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		11450 As	bury Ci	rcle, Ap	t. #326		Solomon	s				Calvert		
neral	Г	<ol><li>Social Security Nu</li></ol>		S. Sex	7. Age (In yrs. Ia		ay) If Under 1 Year	If Under		8. Date of Birtl	n		thplace (S	State or Foreign
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ami	δ	1 Never Marri		ed 1  Yes If Yes, Giv	2 X No		1 ☐ Yes 2 🏋 No			riidari, didi,		Black, White		
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important, it ten 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatore of Fun	neral Service Lic	ensee //			22. Name and Addres			ausch Fi				
any		theyaha	JA About	Van	1	4	P. O. B							A.
	$\vdash$	23a Part 1 Enter th	ne disease or or	omplications that of	caused the doubt	Do not						diid 200		
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			1											
elyf	Medical	29a. Certifier 1	Certifying Pl Medical Exa	hysician: To the be	est of my knowle	edge, dea	th occurred at the time vestigation, in my opinio	, date and	place, an	d due to the cau	ise(s) an	d manner as sta	ated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $08^{\text{Month}}$ 2012 Year Ange1 Roberto Rodriguez 2:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min **Director** N/A 1 X M 2 🗆 F 0 1 0 08/10/2012 Maryland 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Directo MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1616 Neely Road 20903 **USA** within 72 hours after death 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1x Yes 2□No Specify: Salvadorean White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygien of Health and Mental Hygien fitem 27 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roberto Carlos Rodriguez Rina Bexaida Villegas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rina Bexaida Villegas Mother 1616 Neely Road, Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 08-17-2012 Silver Spring, Maryland 22. Name and Address of Facility Cole Funeral Services, P.A. 21. Sig / tun of Funaral Ser 4110 Aspen <u>Hill Rd.#100, Rockville MD 20853</u> 23a, Part 1. Enter the disc complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysiciana Acronia Medical resulting in death) Due to (or as a consequence of): Examiner Anencephaly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been sig should b Completed 2 🛮 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page perform certificate 2 **X** No ☐ Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' Accident Investigation the 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: It the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58667 08-10-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1.12

Registrar
DHMH 17 Rev 06-2011

State

Dr. John Choi 31. Date filed (Month, Day, Year)

AUG 1 6 2012

5944 Hubbard Drive, Rockville,

12-06421	
Gary Wayne R	е

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ry Wayne Re		1- For State Certificate of Death		Menta	al Hygi		20	112	2877
Physicia		1. Decedent's Name (First, Middle,Last)	_			Date of Death		3. T	ime of Death
edical Exami		Gary W. Reeves				Month lugust 25,			632 hrs
		4a. Facility Name (if not institution, give street and number)  288 Jackson Park Road  Port D		ocation of I	Death		4c. County of Cecil	Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	<u> </u>	If Under 2	24Hrs. 8.	. Date of Birth	n(MM/DD/YYYY)		ce (State or
Director		212-50-5252 1 Months	Days	Hours	Min.	5/5/19	947	oreign Country	) MD
		Usual Residence of Decedent				_		Lini	tuelde O'te I lee'te
A BU		10a. State 10b. County 10c. City, Town or Location MD Cecil Port Deposit							. Inside City Limits  Yes 2 No
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle, Last)  James Reeves	18			rst, Middle, M haron	aiden Surname)		
212 buld be i Ment mark	P	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address	(Street	and Numbe	er or Rura	I Route Numl	ber, City or Town,	State, Zip	Code)
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/Medical Examiner	1	Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease							Death
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Box 6876C e death certificate the attending physed for use as the b	Physician/M	4 Pregnant at time of death 5 Other (Speci	fy)						15
hat the ded by the letached		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause giv	ven in Part	1.	23e. Did tol	bacco use contribu	ute to the c	ause of death?
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Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory,	office bu	ilding, etc.	28f	f. Location (S or Town, St		or Rural R	oute Number, City
Ospital hours uneral y fillec		4 Homicide determined (Specify)  29a. Certifier				to the source	-(-) and manned		
To the Hosp within 24 ho To the Fune	Medical	(Check only one)  2  Medical Examiner: On the basis of examination and/or investigation, in my							use(s)
To witi	Me	and manner stated.  29b. Signature and title of certifier  29c.	License	number			29d. Date signed		Day, Year)
		You Un- Yollar ~	O.C.N	1.E.			August 26, 2	2012	
		Name and address of person who completed cause of death (Item 23a)     Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W.	Baltim	ore Stre	et. Balti	imore. MF	21223		
\ s	tate	31. Date filed (Month, Day, Year) / 32. Registrar's Signature			, -uiti				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>012</u> Physician/ Month Lena August 27 8:10PM Sawick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 026-03-9961 1 🗆 M 2 🗹 F 06/23/1916 96 Massachusetts items 23e or 28a-f show ner must be notified at 10a. State 10b. County filed within 72 hours efter deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25958 Timothy Court 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 end 2 should be filed within 72 hours efter dee Department of Health end Mental Hyglene. Importent: if item 27 is merked other then "neturel", or iten eny injury or other traumatic event, the Medical Evaminer ance. 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married <u>۾</u> 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: 3 ₩Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Baptist Charest Lemay Aurora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Marchand - Daughter 25958 Timothy Court, Mechanicsville, Maryland 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Charlotte Hall, Maryland 4 Donation 5 Other (Specify) 08/29/2012 21. Simple Service Licer Seartivasci 22. Name and Address of Facility Brinsfield Funeral Home Kathleen A. Santivasci M00872 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final Onset and Death Fhysician/ disease or condition resulting in death) reace Medical Du to (or as a consequence of): <sup>^</sup>Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of igned by the ettending physicien end be detached for use as the burial-trensit or Attending Physician: The lew requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed within 24 hours efter death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signatu e and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar DHMH 17 Rev 06-201 25365 Point Lookout Road, Leonardtown, MD

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

II

William D. Boyd, 31. Date filed (Month, Day Year) 2 9 2012

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ 2012 1:20AM Lois B. Sellers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Dorchester Cambridge Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) **Director** 047-22-3013 1 🗆 M 2 🔀 F 84 12-12-1927 or 28a-f show Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** death with the Maryland 1 🗌 Yes 2 🔀 No MD Dorchester Cambridge 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Harris Drive 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 🔀 Widowed 4 🗌 Divorced Year or Dates White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Seamstress Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Bonfoey Eva Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sellers /son Harris Drive, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/22/2012 Cambridge, MD Midshore Center 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High Street Newcomb&Collins FH Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
3 months shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Glioblastoma Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 Division of Vital Records, filled in by the funeral director, within 24 hours a

> State Registrar

Medical

Signature and title of certifier

4 Homicide

29a. Certifier (Check

determined

1012 31. Date filed (Month, Day, Year, 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Bramble, Cambridge MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Month 2318 17 Willace Edward Summers August 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Dorchester Dorchester General Hospital Cambridge 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1 X M 2 □ F 1915 July 9, Tennéssee 414-05-5176 97 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Maryland Dorchester Vienna 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21869 USA 114 Market Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify. White Specify: 3 N Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chemical Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Boiler Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Phillips Joseph Summers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P. O. Box 235, Vienna, Maryland 21869 William Summers/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 8/22/2012 Crematory Of Delmarva Delmar, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Service Licens Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, OBSTRUCTIVE PULMONARY DISGISE Immediate Cause (Final CHRONIC disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consecuence or Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown

**Physician** /Medical Examiner

permit. Pages
Department o
Important: If
any Injury or

Physician

/Medical

**Examiner** 

Directo

Funeral

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Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, The Madical Examinat must be notified at

altimore, Maryland 21215-0036

Examiner burial-transi and physician Physician/Medical use as the attending p certificate has been signed by the rector, page 2 should be detached in Completed by director, Be Certification: To this funeral After ithin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu

the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Inpatient 2 PS ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 29a. Certifier

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

performed? Yes 2 No 2 No 1 ☐Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

08

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D69234 2012

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 JEEVAN ERRABOLU

YRN STREET

21613. CAMBRIDGE

22

State Registrar

0

Medical

31. Date filed (Month, Day, Year) AUG 22 2012

29b. Signature and title of certifier



within 2, To the F complet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Timeto D 2. Date of Death 1:10 Physician/ 2012 August Albert S. Salkowski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Care Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Baltimore (Month, Day, Year) Months Days Hours 212-20-7841 Director 1 X M 2 □ F 88 Yrs Feb. 22, 1924 Maryland 2 should be filed within 72 hours after death with the Maryland the end Mental Hygiene.
27 is marked other then "naturel", or items 23e or 28a-f show treumetic event, the Medical Evant retinat by within an 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Direct 1 🗌 Yes 2 🔀 No Maryland Harford Kingsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21087 902 Louis Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WII Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney - CPA State of Maryland 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Stella Mieciecki John Salkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 end 2 s of Health item 27 12628 Fordk Road, Fordk Maryland 2105 Mrs. Claire Salkowski (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of importent: If it eny injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 04, Evans Funeral Chapel Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air 23a. Part Territe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ omenn Cars Medical resulting in death) Due to ( s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). attending physicien and I for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 1 Yes 2 No detached Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

within 24 hours after death.

The Funeral Director. After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 № No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Setto 2 🔼 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: al or Attending F after death, Director: After 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) d title of certifie 29b. Signaty 29d. Date signed (Month, Day, Year) AUGUST 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST N. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Dorothy Adora STRONG Aug. 8:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Williamsport Nursing Home Williamsport Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 29 1 □ M 2 👿 F Months <sup>/ear)</sup>932 Pennsylvania 79 Director 159-26-8205 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 17808 Greenberry Circle 21740 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Office Worker State Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George F. Federer Dorothy M. Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Strong - Son 3006 Spider Lily, San Antonio, Texas 78258 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Res t-Haven Cemetery 18/27/2012 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Unknown Unknown 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of D. ath 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director, At completed filled in by the fu Accident

Suicide

Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signarur and title of cettifier

TW-6 State

Registrar

DHMH 17 Rev 7/2009

580

mpleted cause of death (Item 23a) (Type, Print)

32

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27<sup>Day</sup> Physician/ Month 2012 Year Walter Milton Stuller 12:22 P M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21109 Leitersburg Poke Washington County Hagerstown Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Hours 219-20-2433 **Director** 1 🗶M 2 🗆 F 89 Sept. 15, Pennsylvania 1922 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 😾 No Maryland | Washington Co. Hagerstown 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral USA 21109 Leitersburg Pike 21742 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces' Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 2 No 1940 ve 1942 Baltimore, Maryland 21215-0036 **‡O** 1 □ Yes 2 ဩXNo Specify: If Yes, Give Year or Dates. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry - snould be filed within 7<sub>2</sub> leath and Mental Hygiene. m 27 is marked other than "n ar traumatic event". (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Union Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Stuller Margie Ferguson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21109 Leitersburg Pike, Hagerstown, MD 21742 Mary D. Stuller / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Bethel Cemetery Sept. 31,2012 Cascade, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home <u>Fastern Blvd. N.. Hagerstown, Maryland 21742</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each implementate Cause (Final Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transif law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 Pregnant
9 Unknown 5 Other (specify) Day Pregnant at time of death been signed by the a should be detached f 9 Unknown Iting to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

Jo the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to --dical Be 26. Place of Death (Check only one) Hospital 2 **N**o Other: 1 Tyes 4 Nursing Home 5 Nesidence ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Physician Medical E aminer: O (Check 3 Coffif in only one) oner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

person who completed cause of death (Item 23a) (Type, Print

egistrar's Signatu

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Pennsylvania

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 28, 10:10 A Catherine Marie Spicher August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hacerstown
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)
Oct. 29, 1 Coffman Nursing Home Washington County Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 102 1909 Pennsylvania Director 206-10-9597 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 Yes 2 No Washington Co. Director Maryland Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 **USA** 1304 Pennsylvania Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emma Marie Null 2 William W. Wert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carl E. Spicher/ Son 16124 Shirhan Road, Haerstown, MD 21740

part of Disposition (Name of 21c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 € Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Sept. 1, 2012 hazerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signatu ke of Funeral Service Licery 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approx shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Accident Circhwooningar -2 Has **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to libr as a consequence of): GILP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine been signed by the attending physician and should be detached for use as the burial-transit DEBLLITY The law requires that the death certificate be executed CMY that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No 1 Tes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ပို funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospins. — within 24 hours after death.

To the Funeral Director: A death. 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2012 28 04656 law 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Horara Rum 1790 METMA DADIR mt 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State AUG 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:35 AM Kathleen Elsie SLICK Augus 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Washington Boonsboro 8. Date of Birth (Month, Day Year), Sept. 12,1923 Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 M 2 T F Hours 217-16-2600 Director 88 Yrs Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10d. Inside City Limits 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or U.S.A. Funeral 21740 1008 Brinker Drive Condo 201 Lathleen . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ò þ 1 X Never Married 2 Married Yes 2 K No within 72 hours after white 1 ☐ Yes 2X No Specify: Specify If Yes, Give "natural". Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) accountant interior design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Elsie Barnhart Frederick L. Slick, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 9410 Downsville Pike, Williamsport, Maryland 21795 Debbie Lida - niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State August 30, Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Minnich Funeral Home 22. Name and Address of Facility obert B. Rax 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Enysician/ MEMISTATIC MONTETT disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MONTH CACHENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) FIBRILLATION MRIAL YHARS attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed MONIC Due to (or as a consequence of) PERICAR DIM Physician/Medical MONTHS Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has 1 🗌 Yes 2 🛂 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ျှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I funeral ( 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Continue 11. Ensure All Copies Are

State of Maryland / Department of Health and Mental Hygiene

Continue 12. AMEND ITEM 17 WCHD/TF 28788 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ August 24 Day 2012 ear Madeline Elizabeth STOLTE 8:12p м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4h City Town or Location of Death 4c. County of Death Williamsport Retirement Village Williamsport Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 217-18-6721 Director 1 M 2 X F 88 Feb. 16,1924 Maryland Usual Residence of Decede 28a-f show 10a. State 10h. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland | Washington Hagerstown 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a 1635 Edgewood Place Unit 104 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 white "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the her own home homemaker Be 17. Father's Name (#18:9Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of ge 1 and 2 should be fil nt of Health and Mental : If item 27 is marked ဂ္ Lee Hagan Carmie May Becraft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Gildee - daughter 1934 Londontowne Drive, Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or August 30, Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phinicipo. 2 disease or condition Medical resulting in death) Due to (or as a consequence of) days Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury Examiner Due to for as a pontecuence of: Hospital or Attending Physician: The law requires that the death certificate be executed NO tranand that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Į, in the past 12 months? Month Pregnant at time of death Day Year signed by the a ld be detached f Hinknown g 🗌 Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospita Other: 1 Tyes မြ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Matural 5 Pending injury after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month. Day, Year) 0/2 ompleted cause of death (Item 23a) (Type, Print) 580 21742 MI C Northwin gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 18, Virginia Carol Stearn 2012 7:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 73 Ridge Road, Unit L Greenbelt Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 109-24-5961 1 🗆 M 2 ី N 80 Sept. 18, 1931 Brooklyn, NY 28a-f shov at 10a. State 10c. City, Town or Location Director must be notified 1 X Yes 2 No MD Prince George's Greenbelt ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 73 Ridge Road, Unit L 20770 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc. by Page 1 and 2 should be filed within 72 hours after r ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 🗓 No 1 Yes 2 No Specify: 3 ☐ Widowed 4 🖾 Divorced Completed Specify: White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor 5+ Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unav.) (Unav.) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura C. Heenan / Daughter 10007 Raynor Road, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 8/20/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ erebrovascular disease or condition resulting in death) accident weeks Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Erner Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician d for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dementia Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician; The law page 2 : autopsy performe death? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 2 1 Inpatient 2 I ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to appletely filled in by the funer 1 Natural 5  $\square$  Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trifoslio Mo ephonie 7500 Greenway Cente Dire Green hot Mb 20170

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31. Date filed (Month, Day, Year) 32. Registrar's Signature

29b. Signature and title of certifier

AUG 2 3 2012

Registrar DHMH 17 Rev 06-2011 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Physician/ cal Examine	1- For State Registrar Certificate of Death Reg. No.  1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. T	Time of Death
zer =xemme	Man Day Vari	1715 hrs
	4a. Facility Name (a) not institution, give street and number)  4b. City, Town, or Location of Death  4201 Northyiew Drive  4c. County of Death  4d. County of Death  4c. County of Death  4d. City, Town, or Location of Death  4d. City, Town, or Location of Death	
uneral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace	ce (State or
rector	219-98-3028 1 M 2XF 30 Yrs. Months Days Hours Min. 06/04/1982 Foreign Country	Wishing ten
d at once.	10a. State 10b. County 10c. City, Town or Location 10d	I. Inside City Limits Yes 2 No
event, the Medical Examiner must be notified at once.  De Completed by Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?	
injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		Indian, 8lack,
by Funeral		K
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Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
၂ ဒီ	17. Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Maiden Surname)	
o Be		Code)
2	Darlene Dee Mother 53 Paturent Estate Lothian MD 20	
	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date  20c. Location - City or Town  1 Burial 2 Cremation 3 Removal from State crematory or other place)	
5	4 Donation 5 Other Specify: Riverdale Park 8-22-2012 Kiverdale	MD
injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility WISEMEN FUNERAL HOW	nc 20735
an	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Ap	pproximate Interval etween Onset and
al er	Immediate Cause (Final disease a. Smoke Inhalation and Thermal Injuries	Death
	or condition resulting in death)  Due to (or as a consequence of):	
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C.  Due to (or as a consequence of):	
Exan	or who recently such	
<u> </u>		
8	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnancy 23b. Was decedent pregnancy 23b. Was decedent pregnancy 25b. Was decedent pregnancy 2	
₹	past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day	Year
ician/N	Other (Specify)	
hysician/M	1 Yes 2 No 9 V Unknown 9 Unknown	ause of death?
by Physician/Medical	1 Yes 2 No 3 Probably	
hould be detached for use as the leted by Physician/M	1 Yes 2 No 3 Probably	4 Unknown
page 2 should be detached for use as the Completed by Physician/M	1  Yes 2  No 3  Probably  24a. Was an autopsy performed?  1  Yes 2  No 1  Probably  1  Ver 2  No 3  Probably	4 Unknown
Be Completed by Physician/M	1  Yes 2  No 3  Probably  24a. Was an autopsy performed? 1  Yes 2  No 1  No 2  No 3  Probably  24b. Were autopsy perfor to comple death? 1  Yes 2  No 1  Yes 2  No 1  Yes  25. Was case referred to medical examiner?	4 Unknown  r findings available etion of cause of  2 No
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popiral or Attending Physician: The law requires that hours after death.  Increal Director: After this certificate has been signed by filled in by the funeral director, page 2 should be death.  Certification: To Be Completed by	24a. Was an autopsy performed?  1  Yes 2  No 3  Probably  24a. Was an autopsy performed?  1  Yes 2  No 25. Was case referred to medical examiner?  1  Yes 2  No 3  Probably  24b. Were autopsy prior to comple death?  1  Yes 2  No 25. Was case referred to medical examiner?  1  Yes 2  No 26. Place of Death (Check only one)  25. Was case referred to medical examiner?  1  Yes 2  No 26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death	4 Unknown  v findings available etion of cause of  2 No  ne  vehicle  bute Number, City  iew Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>2</u>01 2 FREDERICK GEORGE AUGUST 29  $a^{\scriptscriptstyle M}$ 6:53 STAHL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Hospital Cecil Elkton . Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. April Day New Jersey 146-16-2931 1925 Director 1 XM 2 F 23a or 28a-f show and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil Earleville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21919 45 Ash Ave. and 2 should be filed within 72 hours after death. Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced Year or Dates. WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Banker - Loan Officer **Bank** Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Louis Stahl Rosie Lichtenauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Roger Stahl (son) P.O. Box 313 Millington, MD. 21651 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 5 Other Galena Cemetery 8/31/12 4 Domation Galena, MD. Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 M00510 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. rant 1. Ente shock, or h Approximate Immediate Cause (Final disease or condition resulting in eath) lar accident Onset and Death Ph\_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dille to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ been signed by the atter should be detached for in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 certificate has autopsy death? 2 No within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ျင 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

HARM

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Shahnawaz Kahn, M.D.

31. Date filed SEP

D0062190

2533 Augustine Herman Hwy. Suite A. Chesapeake City, MD

21915

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

/lark	Andrew	Sands	
	,	941100	

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		1- For State Registrar		C	ertificate	of I	Death				Reg. No.	b \	, i	_	
Physici	an/	1. Decedent's Name (First, Midd	le,Last)							2. Date of De Month	ath Day	Yea	_	3. Time of Death	
Medical Exami	ner			Sands				_	_	August 2	8, 201	2		0915 hrs	
		4a. Facility Name (if not institution	on, give street and n	umber)			. City, Town,	or Locat	ion of Death			. County o	of Death		
		1102 Clark Avenue				Щ	Waldorf					Charles			
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday	)	If Under 1 Y		Jnder 24Hrs ours Min	-			9. Birth Foreign	nplace (State or	
Director		531-70-6988	1 X M 2 F		52	Yrs.	WOTHERS	ays   II	ours Willi	10/29	9/19	59		ntry) VA	
		Usual Residence of Decedent													
W Any		10a. State 10b. County	100		ity, Town or Lo aldor		n							10d. Inside City Limits	
Maryland 28a-f show	ក	MD Charl		VV	aruori									1 Yes 2 No	'
Mary 28a- d at	Director	10e. Street and Number				- 1	10f. Zip Code	•				zen of Wh		,	
3 a or		1102 Clark A	Ave.				2060	) 2			Uni	ted	Sta	ates	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status		cedent Ever in	U.S. 13.		Decedent of s, specify Cub			ecify Yes or N	lo-	14. Race White		an Indian, Black,	
deat or ite	ᆵ	1 Never Married 2 M	1 Yes	2 X No	,						l		•		ı
ral",	ğ	_	orced If Yes, Give Ye or Dates:		1		es 2X					Specify:		ite	_
hours natu	be	15. Decedent's Education (Spe			16a. Dece		Usual Occu t of working I				16b. l	Kind of Bus	siness/Ir	dustry	إ
36 in 72	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)								- 1.6		3 3	
with giene	E	1.2 17. Father's Name (First, Middle,	Last)		Mast	er	Carp			(First, Middle,				loyed	4
filed Hyg	Be C	,	,							ev Jea		•			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	To B	Jack M. Sa: 19a. Informant's Name/Relations			19b. Ma	ilina A	Address (St			Rural Route Nu				Zin Code)	$\dashv$
nore, MD 21215-0036 spes I and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once	-	Tiffany Sand	, , ,, ,			_	•					•		20732	
and 2 and 2 fealth traus	1	20a. Method of Disposition	5/ Daugii		b. Place of Dis	positio	on (Name of			Date	20c.	Location -	City or 1	own, State	ᅥ
Ore ges l t of l		1 X Burial 2 Cremation	3 Removal fi	rom State	crematory o	othe	rplace) M⇔m	Gds	. 09/	01/12	W.	aldo	rf.	MD	
Baltimore, permit. Pages I ar Department of Hee Impurtant: If ite		4 Donation 5 Other St 21 Signature of Funeral Service													4
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Impurtant: If item 27 is marked other than injury or other traumantic event, the Medical		2 il Signature di Pulleral Service	C A	<b>↑</b> M01	517	2, I <b>v</b> ai	me and Addit	355 UI FA	Ray	mond	Fun	eral	Sv	c., P.A.	. l
Physician	$\dashv$	23a. Part I. Enter the disease, or	complications that of	, ,		56. er the	35 Wa mode of dyir	Shli ng, such a	ngtor as cardiac o	r respiratory a	rest, sho	a <u>PL</u> ock, or hea	<u>ata</u> nt	MD 2064 Approximate Interval	
/Medical		failure. List only one cause		1		. 1 •		-	ъ.					Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a Athero Due to (or as a			aı	ovascu	lar	Disea	se					$\dashv$
		Sequentially list conditions,	b.		,										
	miner	if any, leading to immediate	Due to (or as a	consequence	9 of):										٦
	Ē	(Disease or injury that initiated	c. Due to (or as a	consequence	e offi	_		_					_		4
nted d ansit	Exa	events resulting in death) Last	d		3 01).										
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760, icate be physici the buri	3	IF FEMALE:	T	outcome of pr							230	d. Date of	delivery		$\dashv$
876 rtificate ing phy as the	2	23b. Was decedent pregnant in the past 12 months?		oirth		Fetal	death	3 Ect	topic pregna	ncy		Month	Da	ay Year	-
Box 68's death certiff he attending of for use as	Sici			nant at time of	death 5	Othe	r (Specify)				1				Î
De de de r	Physician	Part II. Other significant condit	9 Oliki		A secultise in th		dauly in a nave		- Dort I	1 220 Did	tobooo	uso contrib	nuto to th	ne cause of death?	4
ires that the signed by the detached	Ď				it resulting in tr	ie unc	enying caus	e given ir	ı ranı	_		_	_	ably 4 V Unknown	١
S, F puires n sign	D O	Cocaine and A	TCOHOT US	<u>e</u>						24a. Was					4
cords, law requir has been s	Completed									auto	psy	pr	rior to co	ppsy findings available impletion of cause of	<u> </u>
Rec The Iz	틩									1 Yes	ormed? 2 N		eath? ✔ Yes	2 No	
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner?					26.Pla		ath (Check	only one)		1			
Vit hysici this c	2	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpati	ent :	3 DOA	Other	Nursin	g Home 5	Reside	nce 6 🗸	Other:	Scene	
n of Jing Ph		27. Manner of Death	28a. Date (Month	of Injury n, Day,Year)	28b, Time	of Inju		jury at W	_	28d. Describe	how inju	iry occurre	ed		
ion teath.	aţi.	1 X Natural 5 Pend 2 Accident Inves	fing stigation				1	Yes 2	∐ No						
Division of Vital Records, pital or Attending Physician: The law requirents after death.  eral Director: After this certificate has been siffled in by the funeral director, page 2 should the	ij	3 Suicide 6 Coule	d not be 28e. Plac	e of Injury - Al	home, farm, s	treet,	factory, office	e building	g, etc.	28f. Location or Town,		nd Numbe	r or Rura	al Route Number, City	1
ours cours	Certification:	4 Homicide	mined (Specify)								,				4
Division of Vital Records, P.C. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial—transitions.		Torroom only	nysician: To the bes												
To th within To th	Medical	2 🗸	miner: On the basis and manner s		r and/or invest	yatlor				. uie unie, date					4
	2	29b. Signature and title of certifie	er .				29c. Lice		per					h, Day, Year)	
		-n n					0.0	C.M.E.		<u> </u>	LAug	ust 29,	2012		
		30. Name and address of person					Otro it 5	14:	- MD 5:	202					٦
			nt Medical Exa			ore	Street, Ba	aitimore	e, MD 21	223					$\rfloor$
St Regist	ate	31. Date filed (Month, Day, Year) SEP 1 0 2	2012 Z	egistrar's Sign	ature Lac	N-	1								
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	Di vivi		1. Decedent's Name (First, Middle, L	ast)					Т	2. Date of De	ath			3. Time of Death
	Physicia Medio		Joyce Ann Tho							Month 8	20	ay 2(	) 1 2	1255 Рм
1	Examin	er	4a. Facility Name (if not institution, gi			4b. City,	Town, or l	Location of	f Death			c. County		
	Funeral		618 Greenwood 5. Social Security Number 6.		7202 yrs. last birthday)		orido	GE If Under 2	24 Hrs.	8. Date of Bir		orc	hest	er lace (State or Foreign
	Director	Н	219-88-5675	1 [ M 2 X] E	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)		Count	
1	nd now	_	Usual Residence of Decedent  10a, State  10b. County	48	c. City, Town or Lo	cation			p	8-09-	196	4	MD	Od. Inside City Limits
1	aryland ia-f sho ified at	Director											'	1 Yes 2 X No
B	or 28	ä	MD Dorche 10e. Street and Number	ester IC	Cambride	TE 10f. Zij	Code				10g. C	itizen of V	What Coun	
S	S 23	Funeral	618 Greenwood	Ave. Apt #	<sup>‡</sup> 202	216	513				USA			
- 0	r item		11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deced	dent of His cify Cuban	panic Origi , Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)			e - America k, White, e	
036	s after al", o Exam	d by	1 ☐ Mever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 🗆 Yes	2 <b>X</b> No	Specify:					Blac	
2-0	within 72 hours after death giene. er than "natural", or items , the Medical Examiner m	Completed	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usu	al Occupat	tion uring most o	of working		16b. l	Kind of Br	usiness/Inc	ustry
121	hin 72 ne. than '	mo.	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use	retired)	mig most c	OI WOIKIII	, ,				
9	filed wil al Hygie d other vent, th	Be	17. Father's Name (First, Middle, Last	)	CNA		Т	18 Mother	r's Nama	First, Middle,		_	iver	
'lan	l be fil fental rked tic ev	일	Thomas A. Thom				- 1			ae Be			7)	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	_	19b. Maili	ng Address	S (Street an						tate, Zip C	ode)21613
≥,	and 2: Health tem 27		Keyon Marshall		618	Gree	enwoc				202	, Can	nbrio	ige, MD
Jor	nt of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	Ob. Place of Dispo cemetery, crea	natory or c	the place		Da				City or To	wn, State
ij	permit. Page 1 a Department of I Important: If it any injury or of		4 Donation 5 Other (Special Signature of Faheral Service Lice		Direct			on Facility					DE	
Ba	Pen d my any		D-New York	Mit	Į	enn i 'uner	e Sn	nith	92	4 Rac			216	2
			23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	inplications that caused the one cause on each line.	death. Do not ent	er the mod	e of dying,	, such as ca	ardiac or	ac or respiratory arrest, Approximation Interval Be				
	nysician,		Immediate Cause (Final disease or condition	AIDS	5									Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a con	nsequence of):									
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	uted id ransit	ami	cause. Enter Underlying Cause (Disease or injury) that initiated events	С										
	be executed sician and burial-transit	cal Examiner	resulting in death) Last	Due to (or as a cor	nsequence of):									
				<b>d</b>				-						
.89	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		-			-	•		23d Dat	te of delive	nv.
Division of Vital Records, P.O. Box 6876	requires that the death certificate been signed by the attending phy should be detached for use as the	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tirn 9 ☐ Unknown		Ectopic     Other (sp						Moi		Day Year
0	at the	Phy	9 Unknown Part II. Other significant conditions		nt reculting in the u	indortring.	nauco aivo	n in Port I		T				
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ord	v requirements	lete								24a. Was	/			sy findings available
3ec	he law te has page 2	mo;									rmeg?	p	prior to con leath?	pletion of cause of
ā	sian: T	Bec	25. Was case referred to medical examiner?				26. Plac	ce of Death	(Check o	1 ∐ Yes nly one)	SVAN	01 '	L ies	ZINO
Ž	Physic this ce	우	1 Yes 2 No 27. Manner of Death		2 ER/Outpatier			4 ∐ Nurs	sing Hom	e 5 Resid	dence 6	3 🗌 Othe	er (Specify)	
0 0	ding l th. After funer	cate	Natural 5 Pending  Accident Investigati	28a. Date of injury (Month, Day, Yea	ar) 28b. Time of injury	м  2	8c. Injury a work?		- 1	d. Describe h	now injur	y occurre	ed	
isio	Atter er dea ector: by the	Certificate:	3 Suicide 6 Could not	be 28e. Place of Injury -			_						er or Rural i	Route Number,
<u>S</u>	ital or A  rrs after ral Direct lled in by	al C		building, etc. (S)						City or Tow		•		, l
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical Exam	ysician: To the best of my liner: On the basis of exami	nation and/or inves	tigation, in	my opinion.	, death occi	curred at the	e time, date a	and place	e, and due	to the caus	se(s) and manner stated.
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Σ	only one) 3 L Certifying Nu 29b, Signature and title of certifier	rse Practitioner: To the bes	st of my knowledge		urred at the License r		and place				anner as st (Month, D	
		<	3000	(VI)	CM		5	62	78		(	8-0	21-	12
			30. Name and address of person who		(Item 23a) (Type, F	Print)		.175	, ,	C 1	. /			180
	Sto		31. Date filed (Month, Day, Year)	32. Registrar's S		c fo	150	x/73	55	Seelx	14	V N	い	1302
	Stat Registra		AUG 23 20		A ba	Kel						)		

		State Registrar	Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 1 tem 5 per fh e 31 9-18-12 vt State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2 ()	2 2879
Physicia Medic		1. Decedent's Name (First, Middle, Last, $Zc+ta$	Francine Taylor 8- 20-201	3. Time of Death 2 7: 63 ρ M
Examin Funeral	ner	5. Sy q at Se 7 (1) L 12 O O O O O O O O	Ason Road East New Market Dorch 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Bir	hester
Sirector show at at	or	Usual Residence of Decedent  10a. State 10b. County	M 2 F 53 Yrs. Months Days Hours Min. (Month, Day, Year) 958 N	10d. Inside City Limits
a or 28a-f	Funeral Director	MV Vor Ch	hester East New Market  10f. Zip Code 10g. Citizen of What Co	1 Nes 2 Nountry?
r death with		5832 Richar  11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Ame Rlack Whit	
hours after natural", o dical Exam	Completed by	3 Widowed 4 Divorced  15. Decedent's Edi	ducation 16a. Decedent's Usual Occupation 16b. Kind of Business	ack
1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	0	(Specify only highest grad	College (1-4 or 5+) life. DO NOT use retired)  Certified Medical Aide Nursing	g Home
should be filed with h and Mental Hygier 7 is marked other t traumatic event, th	70 [	19a. Informant's Name/Relationship (Typ.	pe, Print)  18. Mother's Name (First, Middle, Maiden Surname)  Lillian V. Slacur  Spe, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi	<u> </u>
permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		20a, Method of Disposition  1 Burial 2 Cremation 3	10. CUM 5832 Richard Son Rd. East New Ma	VK++, MD.
permit. Page Department Important: any injury conce.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	E. N. Market (PAPetery 8/28/12/2. New Ma 22. Name and Address of Excility / Home, P. A.	316
Physician/		23a. Pan . Enter the disease, or compl sinck, or heart failure. List only on	olications that caused the seath. Do not enter the mode of dying, such as cardial or respiratory arrest,	
Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	pproximate Interval Between Onset and Death
Medical Examiner ician and porual-transit	al Examiner	Immediate Cause (Final disease or condition	a. LUNG CANCER	Interval Between
Medical Examiner ician and porual-transit	<u>a</u>	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. LUNG CANCER  Due to (or as a consequence of):  b. Due to (or as a consequence of):	Interval Between Onset and Death
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requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit as been signed by the detached for use as the burial-transit as been signed.	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	a. LUNG CANCER  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):	Interval Between Onset and Death Onset and Dea
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requires that the death certificate be executed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	Interval Between Onset and Death Onset O
requires that the death certificate be executed  x  been signed by the attending physician and should be detached for use as the burial-transit  a B	Certificate: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con	a	Interval Between Onset and Death
ing Physician: The law requires that the death certificate be executed <b>XX</b> We will the certificate has been signed by the attending physician and when the certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit in a bear of the certificate	Medical Certificate: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con	a	Interval Between Onset and Death

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18 2012 August 12:30 A M Pauline Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Dorchester Chesapeake Woods Cambridge If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 78 May 17, 011-26-8452 1934 Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 525 Glenburn Avenue 21613 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify Specify. White þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Paul Dopart Mary Lopes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trauonce. Elizabeth Campbell/Daughter 121 Canterbury Drive, Felton, DE 19943 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Unity Washington Cem. 8/21/2012 Hurlock, Maryland 4 ☐ Donation 与 ☐ Other (Specify) Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Signatur of Frineral Service Li ensee Approximate Interval Between Onset and Death . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dementia 10 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injuly that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an cate has b autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 huson

State

Registrar

31. Date filed (Month, Day, Year)

AUG 22 2012

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 28796 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Darrell Harry VanDyne  $20\overset{\text{Year}}{12}$ August 16 1:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 226-62-8043 65 **Director** 1 🛛 M 2 🗆 F 8/23/1946 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Gaithersburg Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 401 Blue Silk Lane Apt.B 20879 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No 1 ☐ Yes 2 🕅 No Specify. Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) 12 College (1-4 or 5+) Printing <u>Graphic Artist</u> Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Earl VanDyne Margaret Jane Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Padula Son 18980 2nd Street Whitehall WI54773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Atlantic Crematory 8/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Cole Funeral Services, P.A. 21. Signature of Funeral Service Li 4110 Aspen Hill Rd.#100, Rockville, MD 20853 23a. Part 1. Enter the disease shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. myocardial infarction Onset and Death Immediate Cause (Final acute Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner acute Sequentially list conditions Examine many, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ page 2 should be detached for in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Braton tailurc 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No ☐ Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ျ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of

31. Date filed (Month, Day, Year) **AUG 2 3 2012** 

isaya

andyne,

MD

rson who completed cause of death (Item 23a) (Type, Print)

32. Segistrar's Signature

D74374

Kommineni, MD 9901 Medical Center Drive, Pockville, Many land 20850

12-06462 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James M. Whittington, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 28797 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month August 27, 2012 **Medical Examiner** 1250 hrs McKinley James 4a. Facility Name (if not institution, give street and number) 4c. County of Death Dock at 1089 Puppy Hole Court Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Min. Director Hours 38 Country) M D 212-04-9895 1 M 2 F Usual Residence of Decedent 10 y 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Somerset Crisfield Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Maryland Director 10e. Street and Number 10g. Citizen of What Country? 105 21817 S. A. Main W Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year 1 Yes 2 No specify: Black 3 Widowed 4 Divorced other than "oatural", Specify: Š r Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Laborer 12-th grade 17. Father's Name (First, Middle, Last) Deafood 18. Mother's Name (First, Middle, Maiden Surname Sr. McKinley James Alicia FOSq.Ve 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is 5+ Whittington-wife rrstield 05 MD W. Main 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 8/12 Hopewell Hopewell U.m.C. 4 Donation 5 Other Specify: Cem, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony 30639 Ham Ave, Princess Anne, mo, 21853 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Combined Ethanol and Isopropanol Intoxication Between Onset and /Medical Death acomplicated by Drowning Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g931 9-14-12 sm attending physician or use as the burial -Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown certificate has been signed by the ector, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) of Vital Be Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes funeral 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred subject Certification: ingested ethanol and Isopropanol and drowned 1 Natural hours after death. death. 5 Pending 1 Yes 2 X No the fd 8-27-12 fd 12:33 pn 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1089 Puppy Hole Ct. Crisfield, MD. determined (Specify) Fd: in water by dock \_\_ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 hours at completely

31. Date filed (Month, Day, Year) **SEP 0 5 2012** 

Laron Locke MD.

Signature and title of certifier

32 Registrar's Signature

State Registrar

29b

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 28, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Jerome Walsh Augnth 18 2012 6:56 P M Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u>Charlotte Hall Veterans Home</u> Charlotte Hall Mary's 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗷 M 2 🗆 F Months Days Month, Day June 5 577-42-8340 Hours 80 Director 1932 Pennsylvania Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George Bowie 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13509 Old Chapel Road 20720 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 rr Yes, Give 52-55 Year or Dates, 52-55 1 Yes 2 X No Specify: Specify: white 3 🖔 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Government 12th landscaper Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ David James Walsh Helen Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Pitcher - daughter 8585 Broomes Is. Rd. Port Republic Maryland 20615 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 08/24/2012 1 X Burial 2 Cremation 3 Removal from State Port Republic MD Chesapeake Highlands Memorial Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 151 and Rd. Port Republic, MD 20676 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on a Interval Between Immediate Cause (Final d Death Physician/ disease or condition resulting in death) Deim Medical Due: (or all consequence of: **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has autopsy performed prior to completion of cause of death? this certificate 2 🗆 No Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Allegh. 19, Da 2012 Year Physician/ 8:28 PM Marguerite Winters Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death c. County of Death Prince Geroge's Southern Maryland Hospital Clinton . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 18,1931 578-42-6423 1 🗆 M 2 🔀 80 Director September SC 28a-f shov 10c. City, Town or Location
Upper Marlboro 10d. Inside City Limits with the Maryland Director MD Prince George' ms 23a or 28a-f s must be notified 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I 7214 Arrowhead Drive 20772 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Health and Mental Hygiene. em 27 is marked other than "natural", or itel ther traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Jackson Jerusha Floyd 19a Informant's Name/Relationship (*Typg, Print*)
Lottie Marcia Winters-Adona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7214 Arrowhead Dr. Upper Marlboro,MD Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 8-27-12 Laurel, MD MD National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pridgen Funeral Service 21. Signature of Funeral Service Licenses 9013 Annapolis Rd. Lanham, 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 47 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Disens 100 been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed? death? 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ၉ 1 Inpatient 2 PR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner onte 100/15 If Under 1 Year If Under Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State of Foreign **Funeral** 1 M 2 Months Hours Director Usual Residence of Decedent 28a-f show 10b County 10a. State 10d. Inside City Limits Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 No Oe. Street and Number 9 10g. Citizen of What Country items 23a Funeral 07 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Never Married 2 Married þ "natural", or Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Blac Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than '
injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Der artment of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory) or other place) 20c. Location - City or Town, State 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disse, or complications that caused shock, or heart former. List only one cause on each line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day ate has been signed by the a page 2 should be detached to g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No certificate Hospital or Attending Physician: 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) examiner? 2 No ျပ I M Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or completed filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 \( \sum \) Yes 2 \( \sum \) No Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Raymond Stulting		1- For State	State of Maryl		artment of		d Mental I		2 (	012 2880
Physicia Medical Examir	ın/	Registrar  1. Decedent's Name (First, I Raymond S.						2. Date of Dea Month August 18		3. Time of Death 1325 hrs
		4a. Facility Name (if not inst 3310 North Leisun	titution, give street and n e World Boulevard	*		4b. City, Town, or Silver Spring		ath	4c. County of Montgom	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	<del></del>	Irs. 8. Date of Bir tin. 5/11/2	, 1	9. Birthplace (State or Foreign Country) China
any	-	577-22-4221  Usual Residence of Decede  10a. State 10b. Cod	ent		y, Town or Locati			3/11/	1925	10d. Inside City Limits
Aaryland 28a-f shuw s 1 at once.	Director	Maryland Mon	tgomery	Si	lver Spi	ring 10f. Zip Code		<del></del>	0g. Citizen of Wha	1 Yes 2 No
with the Mr is 23a or 21		3310 North L		d Blvd,		20906				USA  American Indian, Black,
ifter death v	Fune	1 Never Married 2		Forces?	If Y	es, specify Cuban,	, Mexican, Puer		White,	
6 172 hours a an "natura cal Exami	leted by	15. Decedent's Education Elementary/Secondary (0	O-12) College (	(1-4 or 5+)	during me	t's Usual Occupations of working life.	ion (Give kind o DO NOT use re	etired)	16b. Kind of Busi	ŕ
15-003( filed within Hygiene dother thi	$\mathbf{v}$	17. Father's Name (First, Mi	iddle, Last)	<u>i</u> +	Foreign	n Service	18.Mother's Nan	me (First, Middle, M	Maiden Surname)	l Government
D 2121 should be: and Mental 77 is marke		Jesse B. Yau 19a Informant's Name/Rela Margaret Yau	tionship (Type, Print )	er		Address (Street tadium Dr	t and Number or		nber, City or Town,	, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shu injury or nither traumatic event, the Medical Examiner must be notified at once.	ŀ	20a. Method of Disposition  1 Burial 2 Crem	nation 3 Removal f	20b.	Place of Disposi crematory or oth	ition (Name of cem	netery,	Date		City or Town, State
Baltim permit. Pa Departmen Important injury or 1	t	4 Donation 5 Other 21. Signature of Funeral Ser	rvice Licensee		22. N	lame and Address	of Facility Fo	ort Linco	oln Funer	ral Home
Physician /Medical Examiner		23a. Part I. Enter the disease failure. List only one ca	ause on each line. <sub>ease a.</sub> Intraoral G		n. Do not enter th	)1 Bladen ne mode of dying, s	1Sburg F such as cardiac	d. Brent or respiratory arre	twood, MD est, shock, or heart	t Approximate Interval Between Onset and Death
d and the same		or condition resulting in dear Sequentially list conditions, if any, leading to immediate	b	a consequence of						
ıted d ansit	min	cause. Enter Underlying Ca (Disease or injury that initiat events resulting in death) Li	ause red =	a consequence o						
O, e be executed /sician and burial - transi	edical	UNPENDED	AMENDED							
n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	ician/	IF FEMALE: 23b. Was decedent pregnant past 12 months?  1 Yes 2 No 9	t in the 1 Live t	nant at time of de	2 Fet	al death 3 ner (Specify)	Ectopic pregr	nancy	23d. Date of de Month	elivery Day Year
P.O.   res that the signed by t	2	Part II. Other significant co	nditions contributing to	to death but not re	esulting in the ur	nderlying cause gi	ven in Part I.			ute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Box is or Attending Physician: The law requires that the death is after death.  1 Director: After this certificate has been signed by the atter led in by the funeral director, page 2 should be detached for the funeral director, page 2.	Completed		ally, in a					24a. Was a autops perform 1 Yes 2	sy prio m <u>ed</u> ? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital hysician: this certi	To Be	25. Was case referred to me examiner? 1 ✓ Yes 2 No	(Uponital)	Inpatient 2	ER/Outpatient		of Death (Check Other   Nursi		Residence 6	Other: Scene
Sion of Attending Pl death.		27. Manner of Death  1 Natural 5	28a. Date (Month Aug 18, Investigation	e of Injury h. Day Year) , 2012	28b. Time of In 1310 hrs		yat Work? es 2 <b>✓</b> No	28d. Describe h Subject shot	now injury occurred t self	
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2.		3 Suicide 6 6 4 Homicide	Could not be 28e. Plac	ce of Injury - At ho Multi-Fami		t, factory, office bu	uilding, etc.	or Town, St	tate)	or Rural Route Number, City Ilevard , Silver Spring, MD
To the Hos within 24 h To the Fun	edical	one) 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examination a						
0 10	Ž Z	29b. Signature and title of ce	rtifier			29c. License O.C.M			29d. Date signed August 19, 2	(Month, Day, Year)
21	3	30. Name and address of per Donna M. Vincenti,		use of death (Item Medical Exan		W. Baltimore (	Street, Balti	more, MD 212	223	
Sta Registr	te <sup>s</sup> ar	31. Date filed (Month, Day Ye	32. Re	egistrar's Signat	and					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28802 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Andy Josue Barrios Zuniga 2012 August 1338 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Director N/A 1 🕱 M 2 🗆 F 0 1 12 08/16/2012 Usual Residence of Decedent Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location Director Silver Spring MD Montgomery 1 Tes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2702 Parker Avenue 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent 2.5.
Armed Forces?
1 Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☑ Yes 2 □ No Specify: Guatemalan Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alejandro Josue Barrios Maria Ercilia Zuniga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alejandro J. Barrios 2702 Parker Avenue, Silver Spring MD 20902 Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State 8/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Fune all Service Licensee 22. Name and Address of Facility Cole Funeral Services, P.A. 4110 Aspen Hill Rd. #100, Rockville, MD 20853 Part 1. Enter the disease, or o shock, or heart failure. List on mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pulmonary Hypoplasia disease or condition 12min hr. Medical resulting in death) Due to (or as a consequence of) **Examiner** Renal Agenesis <u> 1 hr. 12min</u> Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ō 5 Other (specify) Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 X No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending work Investigation 1 Yes 2 🗌 No Accident 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D50522 8/16/2012

Registrar

DHMH 17 Rev 06-2011

State

file

1500 Forest Glen Road Silver Spring

MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Picard,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical **Examiner** or Location of Death 4c. County of Death **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 🗹 M 2 🗆 F Director DEC. 16, 1963 48 NEW YORK 28a-f shov 10a, State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director W. VIRG. BERKLEY MARTINSBURG 1-Yes 2 No 10e, Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? 23a MORLATT LANE Funeral 278 25404 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married è Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced BLACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working PAPER life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than OFFICE ASSISTANT Elementary/Secondary (0-12) College (1-4 or 5+) NEW YORK NATIONAL RECORDED 12 TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ည WALTER W. ARTHUR ROBINSON GLADYS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health ARTHUR (50N) ANDRE 278 MORLATT LANE MARTINSBURG, W.VIRGINIA 25404 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY SEPTILL, 2012 SMITHSBURG 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FON, Home sury J. 110 WEST SOUTH ST FREDERICA MO 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Seosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy 3 ò Other (specify) Month Day Pregnant at time of death 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, realing occurred at the language of the basis of my knowledge, death opinion at the language and class, and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) RES-000 September 10, 2012 ARVIND PANDE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALLEN 5:50 A M ELIZABSTH SPATANASA 20/1 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Envoy Nursing Home Pikesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 087294 Virginia 69 1943 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location with the Maryland Director N/A Baltimore 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3413 Reisterstown Rd. U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. Black 3 🔀 Widowed 4 🗌 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) /Seconday (0-12) Grade College (1-4 or 5+) Factory Worker Maryland Cup Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evem 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3413 Reisterstown Rd., Baltimore, MD 21215 Ouentin Cannady(Grandson) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Woodlawn Cem. 09/11/12 Baltimore, MD 4 Donation 5 Other (Specify) Sinature f Funeral Service Lio 子の客告が付付ss 哲学でwn Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ CFASBLOUDSCO MISSASE disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Dav 5 Other (specify) certificate has been signed by the a irector, page 2 should be detached to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director; After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 \( \text{Yes} \quad 2 \text{ \sqrt{No}} \) 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

completed within 2

the

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Bux 2413 KATHUSSN C. D'AMON &

31. Date filed (Month, Day, Year, SEP 1 1 2012

(Check

only one) 29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

SEPTEMBEL 5 2012

29c. License number

R088852

Solis Bury, Mary / 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Hogth 29<sup>ay</sup> Physician/ 2012 Kim R. Acosta 6:35A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Joseph Ritchey Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 217-60-2679 **Funeral** Days Months **Director** 1 🗌 M 2 🕱 F Yrs. 04/21/1956 56 Maryland 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State notified at Director 1 XYes 2 No MD N/A Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ıral", or items 23a oı Examiner must be Funera 5600 Pilgrim Rd. 21214 U.S.A death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Flementary/Secondary (0-12th Grade College (1-4 or 5+) unk Westinghouse 2 should be filed with and Mental Hygier 7 is marked other the other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sylvester Curley Nova Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MD21214 Tammie Lee(niece) 6621 Glenbar Ct. Apt C, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
On-site Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State 9-1-12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Joseph Adres Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 21217 MD Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on the hine. Approximate Interval Between Immediate Cause (Final ₽h, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a sunsequence of, Exam and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 2/12/8 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con ute to the cause of death? þ 3 □ Probably 4 □ Unknown 1 Yes Completed Were autopsy findings available 24a. Was an has autopsy prior to completion of cause or death? Director: After this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 21 ER/Outpatient 3 DOA 1 Tes မ 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27 Mann 28b. Time of of Death 28c. Injury at Certificate: Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month,

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 28806 State of Maryland / Department of Health and Mental Hydiene

avid bilali Alic		1- For State Certificate of Registrar		Reg.	No	
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exami	ner	David Brian Ancell  4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Deat	Month D September 2	2, 2012 4c. County of Death	1001 hrs
		1410 Kensington Drive # 203	Hagerstown		Washington	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	_ `	MM/DD/YYYY) 9. Birt Foreig	
Director		234-11-2185 1XM 2 F 49 Yrs.	Months Days Hours Mir	Sept 26		Mest Virginia
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	on			10d. Inside City Limits
<b>≱</b> .π	Ŀ	Maryland Washington	Hagerstown			1 X Yes 2 No
farylar 28a-f : Laton	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Coun	try?
h the d 13a or 10tifie		1410 Kensington Drive, Apt. 203	21742		USA	
215-0036 be filed within 72 hours after death with the Maryland nual Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces? If Ye	s Decedent of Hispanic Origin? ( S es, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
fter de I", or		1 X Yes 2 No	Yes 2 X No specify:		Specify: Whi	te
nours a natura (xami)	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent during me	's Usual Occupation (Give kind of ost of working life, DO NOT use re	work done 16	6b. Kind of Business/Ir	ndustry
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21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner.	Be	James David Ancell		Etta Lyn		
MD 21 d 2 should I th and Mer n 27 is man	မ		Address (Street and Number or Summit Ave. Hag			Zip Code)
e, N l and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposi	tion (Name of cemetery,		20c. Location - City or	Town, State
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatie		21. Signature of Funeral Service Licensee 22, N	ame and Address of Facility Ling Home Cremat erly L. Heckrot	ion Servi	ce P.O. Bo	× 784
		M01651 Dev 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the	erly L. Heckrot  e mode of dving, such as cardiac	te, P.A.	Clarksvill shock or heart	e, MD21029 Approximate Interval
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Records The law requirecte has been a page 2 should	Completed			performe	ed? death?	_
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Spital of cours at filled it	Certification:	4 Homicide determined (Specify) Multi-Family Apt.		or Town, State 1410 Kensington	Drive # 203 , Hage	erstown, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation.				
To 1 With To 1	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
		Carol Hallan	O.C.M.E.	s	September 3, 201	2
gt1		30. Name and address of person who completed cause of death (Item 23a)	Oldina and Charlet Davis	MD 04000		
. /	ate	Carol H. Allan, MD Assistant Medical Examiner 900 W. B  31. Date filed (Month Day Year) 32. Registrar's Signature	allimore Street, Baltimore	, IVID 21223		
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		For State Registrar				nd / Dep		nt of H	lealth		Mental Hy		201	2. 288	07
Physicia Medic		1. Decedent's Name  Dennis	e (First, Middle, L Way		ndrews						2. Date of De Month 09	Day 06	2012	3. Time of Dea 2:11 A	
Examin		4a. Facility Name (if					4b. City		Location			4c. C	County of Dea		
Funeral		311 Jo		arms Lan	7. Age (In yrs.	last hirthday)	If Unde	r 1 Year	len l		Le 8. Date of Bir	th		e Arunde1 rthplace (State or For	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 Never Marri 3 Widowed	ied 2 X Married	1 X Yes If Yes, Giv	2 No		1 Yes				rilouri, oto.,	Sı	Black, Whi	te, etc. hite	
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Hospital or Attending Phys 24 hours after death. Funeral Director: After this etely filled in by the funeral di	Salo	00 0 155 4	No vicio p			-1- ( - (U)			1.1						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2	Medical Exa	nysician: To the b miner: On the bas urse Practitioner	is of examinati	on and/or inves	stigation, in	my opinio	n, death o	ccurred at	the time, date a	and place, a	nd due to the	cause(s) and manner	stated.
To th withir comp	2	29b. Signature and					7	c. License			0		signed (Mon		
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1st		30. Name and addre			e of death (Ite	m 23a) (Type,	Print)		C:	^	ern) e, l				
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5157 AM William Elmer Armstrong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 94 40 onlisbun .oastal 14050;Q WI comico . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year) 212-30-6594 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent 82 08/06/1930 Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Fort Sumter South 21811 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. "Inature!" or items ant. If item 27 is marked other than "nature!" or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Jillicim (7110) 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aluminum Extrusions 13 V.P of Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth William Elmer Armstrong Countess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Armstrong / Spouse 13 Fort Sumter South, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 🛮 Donation 5 🗆 Other (Specify) Anatomy Gifts Registry Hanover, Maryland 09/10/2012 21. Signature of Fundral Ser 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, MD 21076 Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPATH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → ☐ No 24a. Was an After this certificate has Hospital or Attending Physician: The I 24 hours after death. Funerel Director: After this certificate h within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence of Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check To the I within 2 only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARED affellan 31. Date filed (Month, Day, Year)

State Registrar

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	Examin	er	4a. Facility Name (if not institution, give str Union Memorial	,			n, or Location o imore	of Death		4c. C	County of De	ath	
	Funeral		Social Security Number     6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Y		24 Hrs. 8 Min.	B. Date of Bir (Month, Da		g. B	rthplace (State ountry)	or Foreign
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	the Ma or 28a e notif		MD N/A  10e. Street and Number		Baltimo	10f. Zip Co	de			10g. Citize	en of What C		
	h with ns 23a nust b	Funeral	123 W. 29th Str				21218				US		
920	a filed within 72 hours after death with the Maryland that Hygiene.  ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.</li> </ol>	I		of Hispanic Oriç Cuban, Mexican No Specify:	gin? (Specif n, Puerto Rid	fy Yes or No- can, etc.)	- 1	4. Race - Am Black, Wh pecify: B		
21215-0036	within 72 hou giene. er than "natu the Medical", the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give life. D	O NOT use reti	ne during most red)	t of working	7		d of Busines	s/Industry	
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Baltimore,	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)	onovar nom otato	Mt. Zic	on Cem	tery  9					e, MD	
Ba	Depa Impo any il		21. Signatule o Funeral Service Licensee	-1			ddress of Facilit  Nort		rch F e. Ba			ID 212	02
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, b.	cause on each line.	death. Do not enter Nesp (von nsequence of): unlechi		^		-		φ	Approxim Interval B Inserting	ate etween d Death
36	cate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a co									
. Box 68760	e death certific the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 0 \( \text{9} \) Unknown	ic. If yes, outcome of p 1  Live Birth 2  4 4  Pregnant at tim g  Unknown	Fetal death 3	Ectopic preg				2:	3d. Date of o	elivery Day	Year
	v requires that th s been signed by s should be detac		Part II. Other significant conditions conf	tributing to death but n	ot resulting in the u	underlying caus	se given in Part	l. 	23e. Did t	1		to the cause of Probably 4	
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>	l or Attending Ph after death. Director: After th d in by the funeral	Certificate	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)		М	1  Yes 2	_	8f. Location ( Gity or To		Number or F	ural Route Nur	mber,
(	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse		ination and/or inves	stigation, in my	pinion, death or	ccurred at th	ne time, date	and place, a	and due to th	e cause(s) and r	manner stated
É	To the within 2 To the comple		29b. Signature and title of certifier	M·D		AT	cense number	394	.6.	29d. Date	signed (Mo	2.	
	3		RIZQUI 20	mpleted cause of death	MER	Print) 81 <b>TY</b>	Picu	γ	BAL	TWU	orf.	2	1918
	Sta Registr		31. Date filed (Month, Day, Year) <b>CED 1 1 2012</b>	32. Registrar's	Signature	1							

12-06767 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Bob Blake State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death **Medical Examiner** Robert Bobby Blake September 7, 2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5013 East Oliver Street Baltimore n/a 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. Months Davs Hours Director 77 11/15/1934 1 X M 2 F 20-30-6929 Yrs Usual Residence of Decedent 10c. City. Town or Location 10a State 10b Count 28a-f shny permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shm injury nr other traumatic event, the Medical Examiner must be notified at once. Maryland n/a Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5013 East Oliver Street 21205 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14, Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 2 X No Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Electronic Repair 17. Father's Name (First, Middle, Last) Be Stanley Bogoslawski ٩ 19a. Informant's Name/Relationship (Type, Print ) Marcus Blake / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 09/11/12 Metro Crematory, Inc. 4 Donation 5 Other Specify. Signature of Funeral Service Licenses tephanic Custer **Physician** failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last by the attending physician and ached for use as the burial - transit Physician/Medical AMENDEDS NOTED PER ME G931 9/20/12 TRT UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) isigned by the atte 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Chronic Obstructive Pulmonary Disease Completed director, page 2 should 24a, Was an Obesity autopsy performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other<sub>4</sub> DOA this Inpatient 2 ER/Outpatient 3 ٥ 1 Yes After 28a, Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending Yes 2 No filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 Could not be (Specify) Homicide

Northrop Grumman 18.Mother's Name (First, Middle, Maiden Surname) Vensentina Bogoslawska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Spry Island Road Joppa, Maryland 21085 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes To the Hospital or Attending Physician; Nursing Home 5 Residence 6 🗸 Other; Scene 28d. Describe how injury occurred Certification: 24 hours after death. To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 8, 2012 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registrar ORIGINAL OGME

DHMH 17 Rev 1/2001 **OCME 2006** 

1359 hrs

Country Maryland

10d Inside City Limits 1 Yes 2 No

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			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	No. 20 2	28811
	Physicia		Olivia V Brown		2. Date of Death Month	Day Year <b>08 2013</b>	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	7	4c. County of Death	
أرب			Northwest Hospital	Revallston	n	Balti	none
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birtl	nplace (State or Foreign intry)
			Usual Residence of Decedent		0 /1 / /	7	7772
	ryland -f sho ied at	ctor	10a. State 10b. County 10c. City, Town or L	// /			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	3955 Chaffer Koad	2/133	Ĭ	USA	,
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ylar	id be f Menta arked atic ev	မ	Vames E. Brown, Sr.	Anna	V. Br	own	
Maryland	2 should th and M 27 is mar traumat	્	///	ling Address (Street and Number or Rura		/ /	
<u>ē</u>	l and f f Healt item 2 other		Kobert A. Brown Tr. / Ituskand 393 20a. Method of Disposition 20b. Place of Disp		Kanda 11	c. Location - City or	10 2/133 Town, State
E O	Page 1 nent of ant: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of 4 ☐ Donation 5 ☐ Other (Specify)	ematory or other place) US Memoria/ 9-1		altinor	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Va Va	hn C, Gre	ene Funer	al services
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Do	be executed sician and burial-transit		that initiated events c.  Due to (or as a consequence of):				
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687	ertifica Iding p	Physician/Me	IF FEMALE: 23b, Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Data of dali	
Вох	e atter d for u	icial	in the past 12 months?  1 Live Birth 2 Fetal death 3 1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	Day Year
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<u> </u>	Physi this cral dire	은 2	1 ☐ Yes 2 No 1 ☐ Inpatient 2 ► R/Outpati  27. Manner of Death 28a. Date of injury 28b. Time	·	me 5 Residence		(y)
ם ה	nding ath. r: After re fune	icate	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work?  M 1 Yes 2 No	zod. Describe flow iii	ijury occurred	
Division of Vital	or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Str		al Route Number,
	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	d due to the causels	and manner as stat	ed
:	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inventor only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the ca	ause(s) and manner stated.
; i	Vithi To #	_	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			Sandburt M.D	· D0071045	2	eptember	08, 2012
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	DOOT 1645 Print) Court Road, R	andallota	un all	21133
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Agnature	) 10		, , ,	
	Registra	ır	SELIT TOIL CENTRAL D. MANAGE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Sept. Physician/ 201<sup>Yea</sup> Preston Bolden 1:50 P M 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3111 Baker Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director 220-03-5879 1 XM 2 DF 10-25-19 VA should be filed within 72 hours eftar death with the Marylend nend Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show raumatic avent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3111 Baker Street 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. African 1 Never Married 2 Married Completed by 1 🛣 Yes 2 🗌 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. If Yes, Give 3 X Widowed 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) <u>Machinist</u> Monarch Rubber Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bolden, Sr. Preston Ellen Fanny Bolden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Heelth e if item 27 is 1701 Cole Street Baltimore, Maryland 21223 Michael Bolden-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Dapartmant of
Important: If it
any injury or o 1XXBurial 2 Cremation 3 Removal from State MD. National Cem. 09-13-12 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury siclen and burlel-transit the Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a conse physicien Physician/Medical Box 68760 the as ettending i IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year ☐ Yes 2 ☐ No detached 9 Unknown the 9 Unknown Division of Vital Records, P.O. ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cata hes been siç ; pege 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? this certificata 2 No 1 Yes 2 No director, Be 25. Was case referred to cal 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral To the Hospital or Attending Phywithin 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

30. Name and address of person who co

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

npleted cause of death (Item 23a) (Type, Print)

46305

12-06154 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Florence Banks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 16, 2012 **Medical Examiner** Florence Banks 1034 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 727 Druid Park Lake Drive Apt. 14D N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 214-40-3628 09/09/1944 67 1 M 2 F Country) MD Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 10h. County or items 23a or 28a-f show 1 X Yes 2 No MD N/ABaltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Ex-miner must be notified at note. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 727 Druid Lake Park Dr. Apt14D 21217 U.S.A. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No 3 XWidowed 4 Divorced If Yes, Give Year or Dates: Black 1 Yes 2 X No specify: Specify: ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 9th Grade Cook Regional Institute 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ollie Scott Flossie Ward 19a. Informant's Name/Relationship (Type, Print ) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janyse Banks(daughter) 2334 W. Baltimore, St., Balto., MD 21223 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State crematory or other place) Mt. Zion Cem. 08/21/12 Baltimore, MD 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 30500114dlis Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 2121 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Immediate Cause (Final disease a Narcotic Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transi The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g931 9-18-12 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of 5 Other (Specify) death Unknown 1 Yes 2 V No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? 1 ✓ Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No unknown 5 Pending the Director: fd 8-16-12 fd 10:15 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 727 Druid Park Lake Dr Apt 14D Baltimore, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be Fd:Residence To the Hospital o within 24 hours af To the Funeral D (Specify) Apt 14D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 17, 2012 O.C.M.E. D. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G931 0/20/2012 JH of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ 318 M ofense George Fred Bode 201Z Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 9159 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Hours Director 1 X M 2 □ F June 29,1929 Illinois 83 show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Middletown FRederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? perior. Page 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other than 27 is marked othe Funeral USA 21769 7219 Mountain Church Road 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 Yes 2 1 Never Married 2 Married Completed by 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. 1942-45 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Freda Anderson George Fred Bode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7219 Mountain Church Road Middletown, MD 21769 Joyce Bode / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 9/13/12 Woodbine, MD J Fall eral Service Licensee Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Ph\_sician/ Bray disease or condition resulting in death) umuy 3M Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\nearrow$  Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No Funeral Director: After this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X** No ည 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending injury after death. Investigation Μ 1 Yes 2 No filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours Medical 29a. Certifier Spertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 126

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Opal Court

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death EDRGE Physician/ AUBL 0301 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 330 Adams Court Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 213-34-2082 Director **XX** M 2 □ F Yrs 75 12/12/1936 MD Usual Residence of Deceder 10a. State 10c. City, Town or Location Funeral Director 10d. Inside City Limits notified 28a-f 1 ☐ Yes XX No MD Anne Arundel Glen Burnie 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? pe 23a must 21061 USA 330 Adams Court 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? Completed by 9 1 Never Married XX Married XX Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White "natural" 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than 'natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Baublitz, Sr. Ruth Clarke George W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Mrs. Dorothy Baublitz / Wife 330 Adams Court Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 9/8/2012 Glen Burnie, MD Atlantic Crematory 22. Name and Address of FacilitySingleton Funeral & Cremation Sign Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 10 Part 1. Enter the disease, or complications that cau es the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Phylician WINNTHS KINSONS disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No been signed by the a should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 N To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniurv work? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A Accident Investigation М filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of c 29c. License numbe ame and address of per

Registrar

DHMH 17 Rev 06-2011

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 9:40 P M September Physician/ Lurdy Bruch Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda 9850 Singleton Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day, Year) Funeral Days Hours 1 □ M 2 🛣 F 577-84-7184 Director November 11, 1928 Bolivia 83 10d. Inside City Limits permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural", or items 530 cm any injury or other traumatic event. the Maryland ORDER. 10c. City, Town or Location 10a. State 10b. County Director 1 🗌 Yes 2 🔀 No Bethesda Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20817 9850 Singleton Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status Black, White, etc 1 Never Married 2 M Married Š Bolivian White 1 X Yes 2 ☐ No Specify: Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Modesta Uzquiano Adelio Espinosa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9850 Singleton Drive, Bethesda, Maryland 20817 Hans A. Bruch / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of Montgomery crematory or other place) Crematorium, Inc. September 9, 2012 20a Method of Disposition 1 Burial 2 A Cremation 3 Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee MO1305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>Z</sup>Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying signed by the attending physician and debt be detached for use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 1 Unknown Completed To the Hospitel or Attending Physicien: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

☐ Yes 2 🖾 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical 8 examiner' 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: Other: 2 🛛 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b. Signa R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Debrah Miller, CRNP, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2012 Registrar

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Raltimore Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ner rvice (id				Cremat 22. Name a Donal				Home &					ıu
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Box 68760	Attending Physician: The law requires that the death certificate be refort. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	in the past 12 1  Yes 2  9  Unknown	months?		rth 2 ☐ Feta int at time of d wn	death 3 death 5	☐ Cther (s	pregnanc pecify)	У				Mon		Day	Year
計工 fax fo ME	hat the ed by tl detach	y Phy			ls contributing to dea	th but not res	ulting in the	underlying	cause giv	ren in Part I.		23e. Did t	tobacco	use contril	bute to the	e cause of	death?
200	requires the been signed should be	ted b		eco ch	_	CA	0		_			1 🗷	Yes	2 □ No :	3 🗌 Prob	ably 4 🗆	Unknown
33	law rehas be	mple			londona		HY					24a. Was auto	onsv	l pi		sy findings npletion of	
H 6	sician: The law r certificate has b lirector, page 2 s	Be Co	Urina 25. Was case referr		1 inscorio	^			26. Pla	ace of Death	h (Check o	perfi 1  Yes	2	No 1	☐ Yes	2 No	
4	Attending Physician: or death. ector: After this certific by the funeral director,	- To E	examiner? 1 X Yes 2		Hospital: 1 🖾 In 28a, Date of	patient 2 🗆	ER/Outpati		Othe	er: 4 🗆 Nur	rsing Hor	ie 5 ☐ Resi	idence	6 Other	(Specify)		
23	nding l ath. r: After	icate	Natural 2 X Accident	5 Pending Investiga	(Month, 8/13/	Day, Year)	injury		28c. Injury work 1 🗌	7 aτ ? Yes 2 <b>χ</b> □ I		3d. Describe SUBJEC	,	•	0		
#230	or Atte after de Directo in by th	Certificate: To	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be 28e. Place of building	f Injury - At ho , etc. (Specify	me, farm, s	treet, facto	ry, office	11-17	21	Bf. Location ( City or To	(Street a wn, Stat	nd Number	or Rural	Route Num	ber, SE LN
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d	Medical			Physician: To the besaminer: On the basis	t of my knowl					place, and	DENTON I due to the c	ause(s)	and manne	er as state	d.	
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4	w to with the solution of the		<b>)</b>	2		ENF			RI	654	177		281	16/2	012	.,, , , , , , , , , , , , , , , , , , ,	
	15/	19.00	30. Name and addr	·	ho completed cause	of death (Item	23a) (Type,	Print)	10-1	1 7	ije	, Glan	B.	(0)	MN	210	06.1
	Sta	te	31. Date filed (Mont		7	irar's Signat	ture	bay	aspile	u UI	· VC	, 016	100	realic;	(1)	210	» (
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State of Maryland / Department of Health and Mental Hygiene

			For	State of M	larylar					lental Hy	/giene				
			State Registrar	tificate o	of Deat	Reg. No. 2012 288				3   8					
į	Physicia Medic		1. Decedent's Name (First, Middle Charles Frede		Blockston					2. Date of De Month	eath Da 28	y 2	Year	3. Time of D	
150 May	Examir														
	Funeral Director		5. Social Security Number  214-16-8466  Usual Residence of Decedent	6. Sex 7. Ag 1 🕱 M 2 □ F	7. Age (In yrs. last birthday)  93 Yrs.		If Under 1 Year If Under 24 Hours Months Days Hours M			Min. 8. Date of Birth (Month, Day, Ye June 17, 1		(ear) 9. Birthplace (Country) Marylan		ry)	Foreign
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	for	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City	Limits
		Director	J	imore	Ca	tonsvil	l1e							1  Yes 2	≥ 🔯 No
		ralD	10e. Street and Number		- + O'	10f. Zip Code 21228						izen of Wi USA	nat Count	ry?	
21215-0036		d by Funeral	707 Maiden C	12. Was Decedent Armed Forces? 1 🔀 Yes 2	Ever in U.S	S. 13. V		of Hispanic Cuban, Mex	kican, Puerto	cify Yes or No Rican, etc.)	-	14. Race	White, e	tc.	
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5						ng most of working			b. Kind of Business/Industry			
21			10			Mari	ne Engi					eamsl	nip		
Maryland		To Be	17. Father's Name (First, Middle, L William A. Bl							e (First, Middle E <b>the</b> 1 S	,				
Jar			19a. Informant's Name/Relations			1.				Route Numb			te, Zip Co	ode)	
e, l			Mark Albrent 20a. Method of Disposition	Nephew	20b. F	25//.			<del></del>	encia,	T	cation - C	ity or Toy	vn State	
mol			1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S		, 0	emetery, crem lantic	natory or other	place)	1	-2012	1		-	Mary1	and
Baltimore,			21. Signature of Fundal Service L		)									Witzk 21228	
		ı.	23a. Part 1. Enter the disease or	complications that cause	d the deat	h. Do not ente	r the mode of	dying, such	n as cardiac o	r respiratory a	rrest,	<u> </u>		Approximate	
	h sici n Medical		shock, or heart failure. We only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):												
97.	ertificate be executed  ding physician and se as the burial-transit		Sequentially list conditions,	b. —											
09		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):											
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		n/Me	IF FEMALE: 23b. Was decedent pregnant	of <u>pr</u> egna	pregnancy						23d. Date of delivery				
). Box 687	ires that the death certific signed by the attending p d be detached for use as	Physician/M	in the past 12 months?  1								Month Day Year				
ds, P.O.	requires that been signed k should be det	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Completed								24a. Was auto perfo 1 \(\sum \) Yes	psy ormed?	pri		sy findings ava npletion of caus 2  No	
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			2		Death (Check	only one)	-81 77				
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ivisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ						n (Street and Number or Rural Route Number, Town, State)						
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								se(s) and manne	er stated.			
	To the within To the comple	2	29b. Signature and title of certifier	1	Dest of fi	ny knowledge,		ense numb		ce, and due to		e signed (			
			Mhlipa	A -X		MD	P	27330			08	28(1	2_		
			30. Name and address of person v	who completed cause of o	eath (Item	23a) (Type, P	rint)	st, 1	Baltim	dr, MD	212	101			
	Stat Registra	te ar	31. Date filed (Month, Day, Year)	2012 2. Registr	ar's Signa	ure san	Kal			-					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 7:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Adelphi Adelphi Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) Director 241-16-4458 1 🖳 M 2 🗀 F 100 Usual Residence of Deced Dec. 6, 1911 North Carolina 27 is merked other then "neturel", or items 23e or 28e-f ehow treumetic event, the Madical Examicar must be notified at within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's 1 ☐ Yes 2 🔀 No Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 1801 Metzerott Rd. 20783 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Completed Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry end Mental Hyglene. Is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) aborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health end Mental rent: If Item 27 is merked Dixon Blue Bel1 Mallov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diann Dawson / Attorney 2101 Steuben Way, Silver Spirng, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1
Department of I
Importent: If it
any injury or or Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 09/10/2012 Signature of Funeral Service M00382 22 Name and Address of Facility
Rapp Funeral and Cremation Services 933 Gist Ave. Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE TO THRIVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner AGGRESSIVE BEHAVIOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a nonsequence of: signed by the attending physicien end Id be detached for use es the buriel-trensit Exam the Hospitei or Attending Physicien: The lew requires that the deeth certificate be executed CHRONIC MENTAL DISORDER resulting in death) Last Due to (or as a consequence of) Physician/Medical DEMENTIA Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by **Director:** After this certificate has been slin by the funeral director, pege 2 should 1 ☐ Yes ZXX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) |@ 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident
☐ Suicide Investigation 6 Could not be Direct 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, in 24 hours. The Funeral Dire. Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00 12

State Registrar

DHMH 17 Rev 06-2011

7245 HANOVER PARKWAY,

32. Redistrar's Signature

SUITE B, GREENBELT, MD

20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLUBAYO OLUDARA M.D.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 28820 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3:12 AMM Cunningham Doreen A. September 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Howard County Columbia Howard 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days Country) New York Months Hours Director 58 Jul 20, 1 M 2 KF 215-68-8289 1954 Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is merked other than "neturei", or items 23e or 28e-f sho other treumetic event, the Medical Examiner must be notified at Director 1 Yes 2 No Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3010 North Ridge Rd. Unit 602C 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1. Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Maryland School for Elementary/Secondary (0-12) College (1-4 or 5+) 5+ the Blind Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) end Mental h မ Eugene W. Cunningham Sr. Clara J. Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 end 2 st tment of Heelth e tent: if Item 27 i Cunningham /Brother Eugene 11407 Foxtrot Ct. Sparks Glencoe, MD 21152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Depertment of Importent: If It eny Injury or o 1 Burial 2 Cremation 3 Removal from State Sep 12, 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility M0144 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) trost carca DRINGER SOM Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate has been signed by the ettending physiclen end pege 2 should be detached for use es the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

☐ Yes 2 No. death? To the Hospitel or Attending Physicien: The within 24 hours after death.

To the Funsrel Director: After this certificate i completely filled in by the funeral director, peg 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) 24 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedo Cominos long 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chiu 121°0 heuna eptembe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL Baltimore The Johns Hopkins 1+4 **Funeral** Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) July 17 Davs Hours **Director** 219-04-1802 1 🔀 M 2 🗆 F 66 China Usual Residence of Decedent 1946 show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl Maryland Baltimore Timonium 1 Yes 2 X No ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country?
United States ms 23a or Funeral 2318 Wonderview Road 21093 America "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Ford by 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Chinese Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Tailor 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sin Che Sore Sau Ying Yiu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Josephine Y. Chiu/wife 2318 Wonderview Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney valley 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State September Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 9. 2012 Memorial Gardens Timonium, Maryland Signat of Far eral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phylician Onset and Death Adult dieters respiratory disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sep 518 Sequentially list conditions, Physician/Medical Examiner If a n, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a soliseduence off. Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tra attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death , the a 2 No. Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 ☐ Yes 2 ☐ No Investigation Could not be within 24 hours after deatl To the Funeral Director: Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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1800 Orleans St Baltimore

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

KONTOPIDIS

locunis

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🤈 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stephen Patrick Clark September 7. 2012 0701 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 213-48-6679 1**℃** M 2 □ F 51 June 13, 1961 Maryland show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9911 Rogart Road 20901 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5 Software Systems Engineer Defense Contractor other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any finjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leo James Clark Nancy Rexrode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Johnson Clark / wife 9911 Rogart Road Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/12/12 Woodbine, MD 21. Signature I neral Service Licensee <sup>22</sup> Name and Address of Eacility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Pregnant at time of death Day the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? cate has been sig 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page performed? 1 ☐ Yes 2 ☒ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifie 29b. Signatur 29d. Date signed (Month, Day, Year) D0043539 Sept. 7, 2012 no

State Registrar MD 1500 Forest Glen Road Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond White,

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Anne B. Carrick Physician/ Medical 4a. Facility Name (if not in stitution, give street and number, or Location of Death 4c. County of Death **Examiner** TMONE N/A 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Jan 6, 1919 213-01-0082 1 □ M 2 XXF **Director** MD 93 Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director N/A Baltimore MD 1 XXYes 2 No 10e. Street and Number 10f. Zip Code oľ 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Completed by Funeral U.S.A. 21227 3308 Beson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 **XX**No Specify: White 1 Yes 2XX No Specify: If Yes, Give 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 City Bank +1Computer Librarian Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Bachtell Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christie C. Coe (Daughter) Balto, MD 212 Hawthorne Road 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 9/10/12 Glen Burnie, MD 21. Signature of Fureral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as the b IF FEMALE: use yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 mon Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown Yes 2 Unknown 2 No rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mentia 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital ပ 1 Inpatient ER/Outpatient 3 DOA

Physician/ Medical Examiner and requires that the death certificate be P.O. Box 68760

(タンバーンK) イイイル Baltimore, Maryland 21215-0036

the attending physician signed by the at d be detached for director, page 2 should certificate has been the Hospital or Attending Physician: The law this completely filled in by the funeral within 24 hours after death.

To the Funeral Director: After

Division of Vital Records,

Certificate:

1 Yes

27. Manne of Death Natural Acciden 3 Suicide
4 Homicide

5 Pending Investigation 6 Could not be determined

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of injury (Month, Day, Year) 28b. Time of injury

28c. Injury at work? 1 \quad Yes Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D005425

2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATON AV. Baltimore MD-21229 SHAR

State Registrar

Medical

29a. Certifier (Check

only one 29b. Signature

> Date filed (Month, Day, Year) SEP 1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Omar Corbin		1- For State Registrar	State of Marylan		artment of rtificate of		Mental H	, 0	Reg. No.	20	2 28	82	
Physician Medical Examine		Decedent's Name (First, Mid     Omar		yan		Corbin		2. Date of Dea	Dav	Year	3. Time of Death	1	
		4a. Facility Name (if not institu	tion, give street and numb		1	b. City, Town, or Lo		August 3		. County of Oea			
Funeral		John Hopkins Bayvi		and his the day \	Baltimore								
Director													
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City L	Limits	
Maryland 28a-f show d at once.	to	MD NA Baltimore						1 1 Yes 2					
ne Mary or 28s	Director	10e. Street and Number 4404 Planfi	old Arro An	+ 6		10f. Zip Code 2120	16	1	0g. Citiz	en of What Co	•		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral I	11. Marital Status  1 Never Married 2	12. Was Decede	ent Ever in U. es?		Decedent of Hispa es, specify Cuban, M	anic Origin? ( Sp		)-		rican Indian, Black,		
after d			ivorced if Yes, Give Year or Dates:	2 X No	1 Yes 2 No specify:					Specify: B	lack		
hours	ted t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)				's Usual Occupation est of working life, D	n (Give kind of w	ork done ed)	16b. Kind of Business/Industry				
D36 thin 72 ne. than	Completed by					ck Drive	er	ltimore City					
MD 21215-0036 1.2 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	S	17. Father's Name (First, Middle, Last)  Ernest Eugene Corbin  18.Mother						Name (First, Middle, Maiden Surname) Davis Bailey					
2121 2121 Uld be i Mental marke	To Be	19a. Informant's Name/Relation			19b. Mailing				_	•	e, Zip Code) 212		
MD d 2 sho lth and n 27 is		Anne Ware-M	other		1119	North M	lonroe	Street	:, E	3altim	ore, Md	217	
Ore, es 1 an of Hea If iter		20a. Method of Disposition  1 X Burial 2 Crematic	on 3 Removal from	20b. F	Place of Disposit rematory or other	ion (Name of ceme er place)	09/	l <b>T/7201</b> 2	Į.	ocation - City or			
Baltimore, Permit. Pages I ar Department of Hee Important: If itei	ŀ	4 Donation 5 Other 3	Specify:		Woodla			<del>/2012</del>	Wo	oodlaw	n, Md		
Department Department Injury		Xala	Varch		Mai 430	me and Address of Ch F/H	West	Balt	imor	ce, Md	21215		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and											
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Cardiovascular Disease  Due to (or as a consequence of):											
		Sequentially list conditions.											
	Examiner												
ted 1 Insit	E	events resulting in death) Last  Due to (or as a consequence of):											
50, te be executed nysician and burial - transit	를	d.  AMENDED 23a,pt.II,27,per me,g931 9-18-12 sm  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year											
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transi	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcome	ome of pregn	ancy				23d.	Date of delivery	,		
Sox 6876 leath certificat e attending phy for use as the	ciar	Other (Specify)						СУ	Month Day Year				
	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e.											
ires that the signed by 1 be detach	6	Sleep Apnea	uons contributing to dea	ith but not res	sulting in the un	derlying cause give	n in Part I.				the cause of death?		
of Vital Records, ag Physician: The law requir After this certificate has been s meral director, page 2 should le	ompleted							24a. Was a	topsy findings availa	opsy findings available			
tal Reco	티	autop: perfor 1 ✓ Yes 2							rmed? death?				
tal Rec	Re C	25. Was case referred to medica examiner?					Death (Check on			10	3 2 10		
of Viing Physical After this	의	1 Yes 2 No	Hospital: 1 Inpati		R/Outpatient 28b. Time of Inju		Nursing	Home 5 F	Residenc		:	_	
ion C tending eath. or: Aft the fun		1 X Natural 5 Pen	(Month, Day,	Year)	200. Time of hije	1 Yes		od, Describe n	ow injury	occurred		ĺ	
Division rate of a strength of	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.						28f. Location (Street and Number or Rural Route Number, City					
Ospital hours uneral y filled		4 Homicide determined (Specify) or Town, State)  29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place and the table occurred.									_		
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	19	one) \(\sigma 2 \overline{\text{V}}\) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
F % F 8	<b>E</b> :	and manner stated.  29b. Signature and title of certifier			29c. License number			29d. Date signed (Month,			th, Day, Year)	$\dashv$	
	4	1 avaler		O.C.M.E.				August 31, 2012					
of perd	L	Name and address of person Laron Locke MD. A	who completed cause of ssistant Medical Ex			imore Street	Raltimore ME	) 21222				$\dashv$	
Sta	e <sup>3</sup>	1. Date filed (Month, Day, Year)	32 Registra	ar's Signature		more otreet, b		4 1443				$\dashv$	
Registra	_	35711	2012 Beneus	LA.	park								
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DHMH 17 Rev 1/2001 OCME 2006

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			_ TOI	State of Mary	·			d Mental Hy	giene		00005	
			1 - State Registrar Certificate of Death Reg. No. 2012									
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Mary L. Chase					2. Date of De	08 Day 20	1 <sup>½</sup> 2 <sup>ar</sup>	3. Time of Death 3:30 A M	
-	Examin		4a. Facility Name (if not institution, give str 2209 Tory Way	eet and number)		4b. City, Town, o	r Location of D	eath	4c. County Harf			
	Funeral		5. Social Security Number 6. Sex 218-74-2804	F 1	yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi		g. Birthp Count	lace (State or Foreign try)	
	Director		Usual Residence of Decedent		Yrs.			10/13/	1960	Idah		
	aryland a-f sho fied at	Director	MD Harford	1	Forest					11	0d. Inside City Limits  1 ☐ Yes 2X No	
	the Ma or 28; e notif	l Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	s 23e	Funeral	2209 Tory Way			2	1050		USA			
920	e filed within 72, hours after death with the Maryland tral Hygiene. And Hygiene. And cutter than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced	2. Was Decedent Ever i Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🏿 No	an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		ce - America ck, White, e Wh		
Baltimore, Maryland 21215-0036	72, hour	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of	working	16b. Kind of B	usiness/lnc	dustry	
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and	be filed lental Hyg rked oth	To Be	17. Father's Name (First, Middle, Last)  Robert Pavlus	Name (First, Middle en Hersl		e)						
lary	Robert Pavlus  Rathleen Hersley  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Cit.										ode)	
e, Z	and 2 s Health em 27 ther tra		John A. Chase - Spo		2209 0b. Place of Dispo		y, Fore	est Hill,	MD 210		vin State	
mor	age 1 lent of l nt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	natory or other place 7alley Me		3/14/2012		•		
Balti	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signatu & of Funeral Ce Licensee			2. Name and Addre	ss of Facility	Schimune	k Funera			
610 W. MacPhail Rd., Bel Air, I  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate	
	h, sician/		Immediate Cause (Final disease or condition	cause on each line.	n Co	incer					Interval Between Onset and Death	
-	Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):							
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	ecutec and al-trans	Exan	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a cor	sequence of):							
09	cate be executed physician and s the burial-transit	dical Examine	<b>U</b> d.									
687	sertifica nding ph use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pr		7			23d. Da	ite of delive	ery	
). Box	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending prompietely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2.	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnand Other (specify)	су 				Day Year	
ls, P.O.	uires that n signed l		Part II. Other significant conditions control	ributing to death but no	ot resulting in the u	inderlying cause gi	ven in Part I.	23e. Did	./		e cause of death?	
Division of Vital Records,	The law req ate has bee page 2 sho	Completed by						24a. Was auto perf	psy ormed2		psy findings available impletion of cause of	
Ea F	<b>ıyslcian:</b> The iis certificate I director, pag	Be C	25. Was case referred to medical examiner?	itali				Check only one)	4 110			
of Vi	Physion r this of eral direction	မ	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of injury	2 ER/Outpatier 28b. Time of		4 L Nursin	ng Home 5 Resi	dence 6 Oth			
ono	ending eath. or: Afte he fund	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	ar) Injury		? Yes 2 🗆 No					
ivisi)	after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural	Route Number,	
_	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine	: On the basis of examin	nation and/or invest	tigation, in my opini	on, death occurr	red at the time, date	and place, and du	e to the cau	ise(s) and manner stated.	
	To the within То the сопре	Ž	only one) 3 L Certifying Nurse F 29b. Signature and title of certifier	Practitioner: To the bes	t of my knowledge,	29c. Licens		CO2	29d. Date signer			
	10.7		30. Name and address of person who com	unleted cause of dooth	(Item 23a) (Funa F	Do Print)	060	001	9/1	0/	2010	
	101		A toppe Ke	ls 5	00 Upp	rerChe	sape	eake Dr	Bell	ir	MD 21014	
	Stat Registra		31. Date filed (Modific Pay, Year) 2012	32. Registrar's S	9. San	Kal	V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER Marylu Ellen D'Angelo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. JOSEPH MEDICAL CENTER Baltimore <u>Towson</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min (Month, Day, Year) Director 212-34-3513 78 1 □ M 2 🛣 F 1934 May 25, Maryland item 27 ie merked other then "netural", or items 23e or 28e-f ehov other treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County filed within 72 hours efter deeth with the Meryland 10c. City, Town or Location Director 1 🗆 Yes 2 🔯 No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 33 Slavin Court 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes 2 😾 No Specify: If Yes, Give Specify: white 3

Midowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Patient Coordinator Medical Office 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h end Mental h 7 ie merked o Anthony Andrew D'Angelo Lula Virginia Hazelip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Depertment of Health er Importent: If Item 27 le eny injury or other trea once. Samuel Smith/ son Powder Farm Court Perry Hall, Maryland 21128 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/10/2012 | Baltimore, Maryland Metro Crematory, Inc. 22. Name and Address of FacilitCremation Society of Maryland, Inc. re of Funeral Service Licer Custer seeS**te**phanie 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The lew requires that the deeth certificate be executed After this certificate has been signed by the ettending physicien end interestor, page 2 should be detached for use as the buriel-trensh Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Day 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ STROKE 1 Yes 2 No 3 Probably 4 Unknown Completed PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 7 1 Yes or Attending Physicien: 'effer death.'
Director: After this certifice the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 X No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be within 24 hours efter de To the Funerel Directo completely filled In by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospitei 124 hours e Funerei Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

7			Please Type	or Print	in B	lack In	delible Inl	k. Ens	ure All Copie	s Ar	e Legible	
7/			For State	ate of Mar	ylanc				and Mental Hy	_		00027
Ó-			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate of L	)eath	2. Date of De		0.2012	
5	Physicia		Enid Sparks Deutscher	ndorf							7,2012	3. Time of Death 12:50 p M
5	Medic Examir		4a. Facility Name (if not institution, give street ar				4b. City, Town, or	r Location			c. County of Dear	
5.5	4		Oak Crest- Renaissance	e Garder	ns		Parkvill	Le			Baltimor	e
7	Funeral Director		5. Social Security Number     6. Sex     199-16-8458	7. Age (Ir		st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bir Min. (Month, Da Dec. 19	rth ay, Yea <i>r)</i>	9. Bir Co	thplace (State or Foreign untry) nsylvania
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Death	th with the Maryland ms 23a or 28a-f show must be notified at	Director	Maryland Baltimore		Par	kville	9					1 ☐ Yes 2 🔀 No
9	h the	al D	10e. Street and Number	_			10f. Zip Code			10g. C	Citizen of What Co	ountry?
A	death wit items 2: ner must	Funeral	8830 Walther Boulevan	rd, RGT#			21234	i- O-	nin 2 (On naife Van au Na	USA		
7 0	s after dea ral", or ite	by Fu	_ Arn	ned Forces?		If	Yes, specify Cuba	ın, Mexicar	gin? (Specify Yes or No- n, Puerto Rican, etc.)		14. Race - Ame Black, Whit	
S S	2 hours aft "natural", edical Exa	ed k	3 XWidowed 4 ☐ Divorced If You Year	Yes 2 X No es, Give r or Dates.		1	☐ Yes 2 🏋 No	Specify:			Specify: Wh	ite
5 F	72 hours after death with the Maryland n "natural", or items 23a or 28a-f shc ledical Examiner must be notified at	plet	15. Decedent's Education (Specify only highest grade comp			(Give k	ent's Usual Occup ind of work done o	ation during mos	t of working	16b.	Kind of Business	/Industry
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	illed wil al Hygie I <b>other</b> vent, th	Be	17. Father's Name (First, Middle, Last)			REGISI	ered Nur		er's Name (First, Middle			re
ylar	1 and 2 should be filed within . If Health and Mental Hygiene. item 27 is marked other thar other traumatic event, the M	욘	Leslie Terwilliger S	oarks				Lois	s Iva Kesla	r		
P P	shour and last is m		19a. Informant's Name/Relationship (Type, Print	,			•		er or Rural Route Numbe			· ·
£ 1.	1 and 2 soft Health item 27 other tr	contract to	James S. Deutschendord 20a. Method of Disposition				Hunting sition (Name of	Tweed	Dr.Owings		LIs,Mary Location - City or	
$\mathbb{E}\mathcal{N}\mathcal{U}$ altimore, Maryland	permit. Page 1 a Department of h Important: If ite any injury or oth		1 ☐ Burial 2 🂢 Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	al from State	cei	metery, crem	atory or other place		09/08/2012		•	Maryland
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<u>m</u>	any ber		March (115		≥				Road Balti			
7			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the on each line.	e death.	Do not ente	r the mode of dyin	g, such as	cardiac or respiratory a	rrest,		Approximate Interval Between
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+			resulting in death) Last	ue to (or as a co	nseque	ence of):						
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Box 68	requires that the death certificate be been signed by the attending physicis should be detached for use as the but	Completed by Physician/Medica	in the past 12 months?	es, outcome of g Live Birth 2 Pregnant at tir Unknown	Fetal	death 3 🗌	Ectopic pregnand Other (specify)	су			23d. Date of de Month	livery Day Year
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${\cal I}$ Division of Vital Records	The law requate has bee page 2 short	omplet	Dementia	_					24a. Was auto perfi 1 □ Yes	psy ormed?	prior to	topsy findings available completion of cause of
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Š	Physic this ce	: To Be	1 Yes 2 No Hospital	1 Inpatient				4 ∐ Nt	ursing Home 5 Resi			ify) Living
0	ding f h. After funer	cate	,1 Natural 5 ☐ Pending	. Date of injury (Month, Day, Ye		28b. Time of injury	28c. Injury work M 1 🗆	yat ∵? Yes 2. [	28d. Describe	how inju	ury occurred	7
isio	Atten	Certificate:	2  Accident Investigation 3  Suicide 6  Could not be 4  Homicide determined			ne, farm, stre	et, factory, office	163 2	28f. Location (			ral Route Number,
Div	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director,		4 E 1101110120	building, etc. (S	Specify)				City or To	wn, Stat	'e)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the Control of the Contr	the basis of exam	nination a	and/or investi	gation, in my opinio	on, death o	courred at the time, date	and plac	ce, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier		*	E ROMBUGE,	29c. License		te 3 to place, and dile 10		ate signed (Mont	
			I alux m	Bras	re	U C/c	END 1	306	7343		9-7-	12
l'i	60		30. Name and address of person who complete	d cause of deat	n (Item 2	23a) (Type, P	rint)	1 -1	Parkvill.		110 ~	V3 3 //
	Sta	e	Afice BRAZICE 31. Date filed (Month, Day, Year) SFP 1 2012	32. Pigis mr's	Signatu	re,	ny B	W	rar NVIII	, /	WF. O	1234
	Registra	ar	SEP 1 1 2012	Brews	1	1. 160	wed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1 Decedent's Name (First Middle Last) 2. Date of Death September 4 Physician/ 2012 10:15 PM Chester Lloyd Dobbins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 5801 Eurith Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 217-38-1631 1 X M 2 | F 69 Yrs. 02/23/1943 West Virginia 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5801 Eurith Avenue 21206 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 lth and Mental Hygiene. 27 is marked other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 HVAC Technician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Herriet Hearald Clyde Dobbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: If item 27 is any injury or any Edward Dobbins / Son 5627 Anthony Avenue, Baltimore, MD 21206 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 09/11/2012 | Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day Yes 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nskaj aparlino D0057465 9/6/12

Registrar
DHMH 17 Rev 06-2011

State

5 203

Bulhmore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSKajapaksemo

31. Date filed (Month, Par

2835 Smin hv

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of H <i>tificate of D</i>			iene <sub>eg. No.</sub> 201	2 28829	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	_				2. Date of Deat	h Dav Year	3. Time of Death	
	Medic Examin	al er	Dorothy 4a. Facility Name (if not institution, give			4b. City, Town, or			4c. County of De	12 3:35 M4	
مم سيورو			Worthwest Ho. 5. Social Security Number   6. S.	spital ER	rs. last birthday)	If Under 1 Year	In Under 24 Hrs.	8. Date of Birth	Balt	Birthplace (State or Foreign	
	Funeral Director		212-30-0022	☐ M 2 💢 F	79 Yrs.	Months Days	Hours Min.	8-11-193		Country) VA	
	and show 1 at	lor	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Loc	cation				10d. Inside City Limits	
	e Maryl r 28a-f notifie	Director	MD Balt	imore	Winds	or Mill				1 ☐ Yes 2 🔀 No	
	with th	ē	3125 Rheims Road			10f. Zip Code	244		10g. Citizen of What o	Country?	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.	
9036	urs afte ural", c	ted by	3√2 Widowed 4 □ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 💢 No	Specify:		Specify: Afr	rican-American	
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212	d within lygiene. her tha nt, the I	Be Co	Elementary/Seconday (0-12)  9th	College (1-4 or 5+)		Assistant			SpringField	State	
land	be file lental H rked of tic ever	To B	17. Father's Name (First, Middle, Last)  George Greenaway				18. Mother's Nar	ne <i>(First, Middl</i> e, <i>N</i> <b>Faster</b>	Maiden Surname)		
Maryland 21215-0036	should N and N is ma		19a. Informant's Name/Relationship (7			ng Address (Street a			City or Town, State,	Zip Code)	
re,	1 and 2 of Healtt item 2 other 1		April Williams/ Grands 20a. Method of Disposition	20	b. Place of Dispo	sition (Name of	1		20c. Location - City	or Town, State	
Baltimore,	t. Page tment c tant: If tjury or		1 → Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State (fy)	edar hill	Cenetery	9-1	3-2012	Glen Burnie,	MD	
Ba	permir Depar Impor any in	ij,	21. Signa of ungral Service bi		92	. Name and Addres 200 Liberty	s of Facility WY Rd., Rand	allstown, N	D 21133	f Enlto. Co.	
	25a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
3-4	Ph_sician/ Medical		tmmediate Cause (Final disease or condition resulting in death)	a Due to (or as a cons	ASCI	/ D				Onset and Death	
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3760	ficate b g physi as the b	Medical	IS SELVING	d				-			
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year	
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s, P.O.	es that signed I I be det	by	Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	ınderlying cause giv	en in Part I.			e to the cause of death?  Probably 4XUnknown	
Division of Vital Records,	w requires s been sig should b	Completed						24a. Was a	n 24b. Were	autopsy findings available to completion of cause of	
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Jo L	ling Ph n. After thi funeral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year	28b. Time of	28c. Injury work	at ?		ow injury occurred		
isioi	Attencer death ector: by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined				Yes 2 No	28f. Location (St City or Town	treet and Number or	Rural Route Number,	
Ω̈́	pital or ours aft eral Dir filled in		29a, Certifier 1 Certifying Phy	rsician: To the best of my kr		occured at the time	date and place	1		stated	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	niner: On the basis of examingse Practioner: To the best of	ation and/or inves of my knowledge,	tigation, in my opinio death occurred at the	n, death occurred time, date and pl	at the time, date ar ace, and due to the	nd place, and due to the cause(s) and manner	ne cause(s) and manner stated.	
	To with		29b. Signature and title of certifier	(D)	11	29c. License	number	2	29d. Date signed (Mo		
	41		30. Name and address of person who	completed cause of death (	(Item 23a) (Type, F	Print)	71073		09/0	0/10	
	Sta	te.	NWH ER, 31. Date filed (Month, Day, Year)	5401 011 32. Registrar's Si	Convot ignature	Road,	Randal	botom,	MP 2	//33	
	Registr										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Basil Boyer Day, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 28830 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1722 hrs Medical Examiner Basil Boyer Day Jr. September 8, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2804 Rainbow Drive Westminster 9. Birthplace (State or 5. Social Security Number 6 Sex If Under 1 Year | If Under 24Hrs B. Date of Birth(MM/DD/YYYY) 7. Age (In vrs. last birthday) **Funeral** Director 54 1-14-1958 Country) MD 2 XM Yrs Usual Residence of Decedent in y 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Westminster 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2804 Rainbow Dr. 21157 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 1 Yes 3 Widowed Specify: White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Church Minister 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 2121 Basil Boyer Day Be Sally Jo Eisenbeis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy T. Day-wife 2804 Rainbow Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State South Carroll Crem 9-12-12 Sykesville, MD Donation 5 Other Specify 22. Name and Address of Facility Fletcher Funeral & Cremation ture of Funeral Service License Main St., Westminster, MD 21157 23d. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? Yes 2 ✔ No certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes ို 28a. Date of Injury FOUND: Pay, Year) After 27. Manner of Death 2Bb. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject ahnged self 1 Natural FOUND: Division Pending 1 Yes 2 ✔ No death. Sep 8, 2012 1655 hrs 2 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be or Town, State) 2804 Rainbow Drive, Westminster, MD determined (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 9, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. P Igistrar's Signature e filed (Month, Dey, Yea State

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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Man 3 Widowed		Armed	Forces? es 2 Give			Was Decedent f Yes, specify (				Rican, etc.)			ck, White,	
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Division	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inod   28e. Pla	ace of In ilding, et	jury - At hoi tc. (Specify)	me, farm, str	eet, factory, of	fice			28f. Location ( City or To			er or Rur	al Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 06ª Perry Douglas Darner 2012 1:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Mt. Airy Kline Hospice House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-36-1122 Director 1 □ M 2**X** F 92 July 31, 1920 Maryland or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 💥 No MD Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 3643 Jefferson Pike 21755 USA death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married 2 XNo 72 hours after Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed and Mental Hygiene.
is marked other than "naturaumatic event, the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rodney Darner Dorothy Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trauonce. 5536 Catholic Church Rd. Jefferson, MD 21755 Ralph D. Brown / friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Final Journey Crematory 9/12/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Aneral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Metastatic Colon Cancer 8 months Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Records, P.O. Box 68760 ası nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No for Day Month Year Pregnant at time of death 1 ☐ Yes ∠∡₃ 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed? Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dther (Specify) hospice this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death.

I Director: After to the funeral of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours a Funeral ! Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D31761 101 2012

IDV State Registrar

Brian M. O'Connor. MD 501 W. Seventh St. Frederick, MD 21701 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gerard DiCarlantonio Joseph Sept 2012 3:30 AM<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Kline Hospice House</u> Frederick County Mount Airy 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) **Director** 213-54-7938 1 X M 2 □ F 49 Jan. 7, 1963 Washington, D.C. Usual Residence of Deced or 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be myttled at 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Loganberry Court <u> 21701</u> <u>U.S.A</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bus Route Supervisor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental I 7 is marked o ၉ Norman L. DiCarlantonio Janet D. Crother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: if item 27 is any Injury or other trau Patti S. DiCarlantonio (Wife) \$06 Loganberry Ct., Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 9/12/12 Woodbine, Maryland Signature of Figureral Service Licensee Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 33 months Physician/ disease or condition resulting in death) Metastatic Colon Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sloian and burial-transit death certificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of): Physiclan/Medical attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🐼 No ည hours after death.

neral Director: After this or y filled in by the funeral dis 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home 5 🗆 Residence 6 🕱 Other (Specify) hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) hours 8 24 hours e Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the F Certifying Nurse Prastitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c. License number D38509 29d. Date signed (Month, Day, Year) 9/10/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas W. Koutrelakos, M.D. 10710 Charter Dr. Suite G020 COlumbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

SEP 1 1 2012

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George Joseph DeMarco September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Howard Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours 209-12-1008 Director 1 AM 2 F Yrs. 86 April 1,1926 Pennsylvania i Hygiene. other then "neture!", or items 23e or 28e-1 shovent, the Modical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City Maryland Howard 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21043 8204 Tall Trees Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Executive Technology other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ౖ౭ Michael DeMarco Helen Quigg 1 end 2 should of Health end N fitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (X-Wife) 4936 Columbia Road Apt 2; Columbia, Maryland 21044 Marie DeMarco 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date .. Page 1 permit. Page 1
Depertment of Importent: If it eny injury or o 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 9-7-2012 Clarksville, Maryland 21. Signature of Funêçal Serviçe Licensee 22. Name and Address of Facility Witzke Funeral Homes, Had M01050 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician CHRONIC OBSTRUCTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Éxamine Sequentially list conditions, if any, leading to immediate cause Finer Underlying Cause (Disease or injury Due to (or as a consequence of): burlel-transit end that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien of for use as the burle Physician/Medical or Attending Physician: The law requires that the death certificete be Box 68760 IF FEMALE: yes, outcome of pregnancy
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☐ Yes 2.20 No this certificate 1 ☐ Yes 2 ☐ No he Hospital or Attending Physician: Thin 24 hours efter death.
the Funerel Director: After this certificatiopietely filled in by the funeral director, p 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 🗷 No ٥ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Seplember 3 vot 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBAS SYED Q. 6336 Cedar have

State Registrar 31. Date filed (Month, Day, Year)

SEP 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **60** 053 20°12 1:55p. Victor Μ. Dare Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 30 4 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Days Hours Months Director 1 ₹ M 2 □ F 212-44-9790 MD 66 Yrs permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Importent: If item 27 is marked other then "neture!", or items 23s or 28s-f show any injury or other treumetic event, the Medical Experiment to marked anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore K☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 2521 Reisterstown Road 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12th grade College (1-4 or 5+) Handyman Various Jobs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Dare Frances Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Dare-Sister 617 Hillen Road, Towson, Md 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State On-Site 9/12/2012 Baltimore, Md 4 Donation 5 Other (Specify) e Funeral Service License March Hy H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying To the Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours effer deeth.

To the Funerei Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacgo use contribute to the cause of death? Completed by CEREBROVASCULAR ACC 100NT 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 PNo 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number se of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 Pay Mabel Lorraine Davis 20T2 11:35 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rock Spring Village Forest Hill Harford 5. Social Security Number **Funeral** If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours **Director** 213-20-4682 89 07/24/1923 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Harford Abingdon 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3007 Scotch Ct. 21009 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed 3 Widowed 4 Divorced Specify. White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 2 should be file Ith and Mental H 27 is marked of traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) James H. Allen Mabel V. Truett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau John G. Davis, Jr. - Son 403 Montgomery Ct., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burjal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Moreland Cemetery 09/07/2012 Baltimore, MD 21. Signat Ir of Fun rai Cervice 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final lita Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Tetal Co.
Pregnant at time of death in the past 12 months? Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I performed 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ို Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Acciden Accident 1 Yes 2 No nvestigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 615 W. Mac Pha. 1 0~2 BRANNED ZIVIY

Registrar

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JIK OIK		1- For State	SI	ate of r	viaryianu	-	rtificate of			id Mental i	1yg:		a Na	20	12	2	883
Physicia	n/	Registrar 1. Decedent's Name	First, Midd	le,Last)								Date of Deat Month	ng. No. Day			3. Time of I	
Medical Examir	ier	Matthew									S	eptembe	r 4, 20			0730 h	irs
		4a. Facility Name (i 4300 Daytor			et and number)				more	r Location of Dea	th		4c.	County of	Death		
Funeral Director		5. Social Security N 216–15–86	599	6. Sex		e (In yrs.	last birthday) 26 Yrs	Mont	der 1 Yea		in.	. Date of Bird April		][	Foreign	place (Stat Balt <sup>ntry)</sup> Mary	imm
any	ŀ	Usual Residence of 10a. State	Decedent 10b. County			10c. City	, Town or Locat	ion								10d. Inside	
Maryland 28a-f show d at once.	ত্	Maryland	Harfor	£		Whi	te Hall						.=				2 X No
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15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.		11. Marital Status		12.	Was Decedent			s Deced		spanic Origin? ( \$			U.S	4. Race		an Indian, 8	Black,
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imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental isnt: If item 27 is marked or other traumatic event,		20a. Method of Disp	osition		, ,		Place of Dispos crematory or oth	ition (Na	ame of ce	emetery,	Da	ate	20c. Lo			own, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If iten miury or other tr.		4 Donation 5	Other St	necify:		Eva	ans Funer	al Ch	apel		201	ær 07 <b>,</b> 12	For	est Hi	ш,	Maryla	ınd
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic.		21. Signature of Fur	P &	Secret J	1 (1)	. Test  543)		ins Fi	unera	s of Facility 1 Chapel & ive, Force	Cr	emation	Serv	ziœs j			
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep	eartment of Health and M	1ental Hyg	giene 2012 28838
			Registrar	rtificate of Death		Reg. No.
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Dea Month</li></ol>	
and any	Medic	al	Claude T. Davis		Septemb	er 8, 2012 7:21 A M
ر	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			5909 Willow Knoll Drive	Derwood		Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent 1 ⋈ M 2 □ F 80 Yrs.		June 10	, 1932 Michigan
	and show	ò	10a. State 10b. County 10c. City, Town or L	ocation	\ <u></u>	10d. Inside City Limits
	taryla 3a-f :	ect	Maryland Montgomery Derwood			1 ☐ Yes 2 🛣 No
	or 2	۵	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	within 72 hours after death with the Manyland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	5909 Willow Knoll Drive	20855		United States
	eath ems	5		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
9	or if	by	1 ∐ Never Married 2 bxt Married   1 bxt Yes 2 ∐ No		Rican, etc.)	Black, White, etc.
21215-0036	ırsaf ıral" Exa	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. Korea	1 ☐ Yes 2 🙀 No Specify:		Specify: White
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yla	Men Men narke		Claude H. Davis	Florence	Belkof	er
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3	und 2 lealth im 2 her t			Willow Knoll Driv		
ore	ela tof Hite orot	- 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	ematory or other place) Sept	Data 16,	20c. Location - City or Town, State
Ē	Pag tmen tant: jury			s Cemetery 2012		Derwood, Maryland
Baltimore,	permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau			22. Name and Address of Facility	mal II	Declared 11 c Tree
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×	eath certificat attending ph d for use as th	ian	in the past 12 months?			23d. Date of delivery  Month Day Year
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	24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred a	the time, date a	nd place, and due to the cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
			Affaggerty MD	D32407	1	September 10, 2012
	N. W.		30. Name and address of person who completed cause of death (Item 23a) (Type,			
	12, 0		Joseph M. Haggerty, MD 9707 Medical		ockvi114	e. MD 20850
	Sta	te	31. Date filed (Mooth Day, Year) 2012 37. Registrar's Signature	- d A	- CIN TITE	-, 12 2000
	Registr	ar	31. Date filed (Mooth Pay, Year) 2012 37. Registrar's Signature	There		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 7. 2012 Donald Sterling Diehl 11:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Village Health Care Gaithersburg Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min 223-32-8872 **Director** 1 X M 2 □ F 83 October 13, 1928 Pennsylvania Usual Residence of Decedent show within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24425 Hanson Road 20882 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 IX Yes 2 No If Yes, Give Korea 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Korea White Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) United States marked other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. the Clerk Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) oft. Page 1 and 2 sh.
ont of Health and Inc.
's item 27 is marked.
'r traumatic eve Earl Cline Diehl Icie Omega Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Catherine Diehl / Wife 24425 Hanson Road, Gaithersburg, Maryland 20882 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 14, 2012 21. Signature of Full ral Service Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 20850-2805 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. nterval Retween Immediate Cause (Final Onset and Death Physician disease or condition Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Dysphagia and Due to (or as a consequence of): resulting in death) Last attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death 2 No a 🗌 Unknown g Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Colon Cancer Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy fi*n*dings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined. Medical 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number LUD D41162 September 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Germantown, Maryland 20874 Vinu Ganti, M.D. 31. Date filed (Month, I 32. Registrar's Signature 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Day 70/2 1344 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County Howard General Columbia 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday If Under 1 Year I If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Hours Director 231-46-3089 77 Virginia Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shorexaminer must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 213 Westport Bay Drive, Apt 102 U.S.A. death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ► No If Yes, specify Cuban, Mexican, Puerto Rican, etc. and Mental Hygiene. þ Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify: **Black** Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charlie William Upshur Effie Sarah Custis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Philip Dashiell (husband) 213 Westport Bay Drive, Apt 102 Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Veterans Cem. 9-11-2012 Crowns Ville, Maryland Signature of Juneral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Toh Columbia, Maryland 21045 5555 Twin Knolls Road 501 MUSOY Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atheroschrotic coronary vasular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabeks 1 Yes 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page performed<sup>a</sup> 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, မှ 1 Inpatient 2 VER/Outpatient 3 IDDA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu DØ0533/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane, Columbia, MO 21044 Michelle Hengseler, NO:

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh g931 9-11-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 6 2012 LINDA RUTH ELDRIDGE 9:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs, last birthday) Hours 381-72-4325 Director 1 M 2 F 1959 MICHIGIAN JULY 21 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MO FREDERICK FREDERICR 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? JUBAL WAY Funeral 819 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: BLACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home House wife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I.P. CHILDRESS MELTON MINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUBAL WAY FREDERICK MD ZITOI MILTON ELDRIDGE (Hus) 819 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SMITHSBURG CROM SEPT. 7,2012 SMITHS BURG 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ARY L. ROLLINS FUNDUICHEME 21. Signature of Funeral Service Ligensee suy 2. FROSBRICK MD ZI701 110 WOST SOUTH ST 23a. Part 1. Enter the disease, or conshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) preast ea ~ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? .24 hours after death. 9 Funerel Director: After this certificate has been sig lietely filled in by the funeral director, page 2 should t 1 Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and Title of certifie 29d. Date, signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monto MAL PILONE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore n/a 5. Social Security Number 6. Sex 7. Age (In yrs. Jast birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Min 1 🗆 M 2 🕽 1928 Georgia 256-30-0802 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland n/a Baltimore 1 X Yes 2 No 10e. Street and Number P 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1036 Hewitt Way 21205 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white "natural", Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ٥ William Grav Hattie Mayberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Mullins/daughter 1054 Doyle Road Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Metro Crematory, Inc. 09/06/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. Custer eral Service Licen 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, it any, eacing to immediate cause. Enter Underlying Examine for use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 4 Pregnant g Unknown Pregnant at time of death Month Day Year been signed by the s a Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 prior to con death? autopsy After this certificate Yes 25. Was case referred to medical examiner? Be funeral director. 26. Place of Death (Check only one) 2 No Other: မှ 1 Yes ER/Outpatient 3 DOA Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending death. Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month,

MD

21224

DHN'S

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin ABADIR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 7:13AM 2012 Ruth Lyon Elwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Greater Baltimore Medical Cente Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Unkn. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/19/1917 Funeral Days Hours Min Director 1 🗆 M 2 🖄 F 235-14-3814 95 Usual Residence of Decedent show r then "neturei", or items 23a or 28e-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD **Baltimore** Lutherville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 508 Brightwood Club Drive 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 Yes Itimore, Maryland 21215-0036 filed within 72 hours efter 2 No 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pege 1 end 2 should be filed within 7 Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then eny injury or other treumetic event Elementary/Secondary (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Lyon Hazel Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy E. Griscom / Daughter 4650 Broad Branch Road, NW, Washington, DC 20008 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 D Burial 2 D Cremation 3 D Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/11/2012 Beltsville, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshal Duck Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, (ereprovancular disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Chief and the Course (Pierses) Examine Dun to (or as a consequence of): Physicien: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last ete has been signed by the attending physician and page 2 should be detached for use as the buriel-trensl Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has autopsy performed 1 Yes 2 No 1 Yes 2 No To the Funerei Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 D No မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospitei or Attending 24 hours after deeth. (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number M.D D 63540 2012

DHMH 17 Rev 06-2011

State

Registrar

Street Ballimore

MD

Charles

32. Registrary Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

Jigar Shah

31. Date filed (Month, Day, Year)

SFP 1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#18 Per FH G931 9/25/2012 JH
State of Maryland / Department of Health and Mental Hygiene 2 1 2

Amend #1 per md G935 12/6/12 trt
Certificate of Death

Reg. No. 28844 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death 7:44 A M Physician/ Marian Edell Francis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OAKS AVENUE FAIR BAUTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Months Country) 212-26-2566 Director 1 □ M 2 🔀 F 86 Yrs. 11925 MID 10 22 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho or 28a-f shov 10a, State the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6604 FAIR DAKS AVENUE 21214 1154 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Department of Health and Ments Important: If Item 27 Is marken any injury or any injur ည DAVIS FLOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen DAUGHTER 4901 Ave.BALTO TUCKER Md. 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON 19/12 BALTIMORE, Md 4 Donation 5 Other (Specify) FORES! Funeral Geryl e Licensee 21. Signat 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCKS nce. mo1553 4905 BALTO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Thenosde 10 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (ur as a consequence of): if any leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as the the attending IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate Yes 2 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **U**Natural 5 🗌 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 Yes 2 No hours after death. М Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of pertifier 29c. License number 30. Name and address of pe 23a) (Type, Print BCB 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Genevieve Flowers 4< PM 2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death East Struthmore Baltimore Knure If Under 1 Year If Under 24 Hrs. 9. Birthplace State of Erreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🛛 F Months 220-20-2733 Hours N. Carolina 82 129264 1929 **Director** Vrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XYes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 743 Mello Ct. 21205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry, al (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other transmets. 12th Grade (0-12) College (1-4 or 5+) Dietary Technician Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Samuel Flax Dorothy unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Mitchell(daughter 743 Mello Ct., Baltimore, MD 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 \_Burial 2 XCremation 3 \_ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) site Crematory O Baltimore, 21. Signature of Funeral Service Licenses ා පිට්ට්ර්ර්ජිss පිට්මේ Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, Funeral Home PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) dementio advanced 1895 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? as S After this certificate har funeral director, page performe 2 🔲 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

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dress of person who completed cause of death (Item 23a) (Type, Print)

Holder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20/ Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** 4c. County of De 110050 1/0 mon asey 200 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours Director 133-24-0207 1 □ M 2 🖾 F 80 May 7, 1932 New York or 28a-f show 10a State 10b. County ir than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No Brookeville <u>Maryland</u> Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20833 United States 19109 Georgia Avenue #212 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba filed hand Mental H is marked of မ Florence Domanski Andrew Bartkowiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 sl of Health a item 27 is 17517 Collier Circle Poolesville, MD 20837 Carol Mayer / Daughter 20a Method of Disposition Date 13 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pege 1 Department of H Important: If ite any injury or ot Gate Of Heaven Cemetery Cemetery Sept. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment Silver Spring, Maryland 2012 Signature of Funeral Service License 22 Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, 300 W. Montgomery Ave. Rockville, MD ach M01662 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or conditi-resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence been signad by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) 9 Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes No Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b director, page 2 s autopsy Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Certificate: To 2 🗆 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 31 2012 Investigation 6 Could not be 0900 M 2. No 7-2/1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Part Indus Number) City or Town, State) Type or Part Indus Number (Street and Number of Part Industrial Number o determined Rebab CTT NUY4173 X Medical Certifying Physician: To the best only knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one are and table of certifie 29d. Date signed (Month, Day, Year) 9-8-12 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, Maryland 20855 Debrah Miller, CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

DHMH 17 Rev 7/2009

OV

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a Copies are Legible. The Copies Are Legible. The State of Maryland / Department of Health and Mental Hygiene For State Registrar 28848 Reg. No. 201 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Scotember 6, 2012 **Physician** 1359 1 Faison Jennail /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country)
 MD June 2, 1960 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months MD 52 213-80-7211 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10h County 10a. State notified at 1 X Yes 2 ☐ No Director Turner Station MD Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number Examiner must be 21222 USA 108 Chestnut Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Prep Cook 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Demera George Faison 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau Baltimore, MD 2710 Lodge Farm Rd. Faison/Daughter Gia D. Place of Disposition (Name of Meter Greenattontye)

Cedar Hill Cemeters 20c. Location - City or Town, State 20a. Method of Disposition 1-Burial XX Cremation 3 - Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility James A. Morton & Sons F. H., Inc. 21. Sgreture of Funeral Service Licensee 1701-31 Laurens St. Baltimore, MD 21217 That 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nock, or heart failure. List only one cause on each line. Immediate Cause (Final dise se or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury) Examiner Due to (or as a consequence of): burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical death certificate be the as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Live birth 2 Fetal death Month Year Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Wunknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No Yes 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be xaminer? Hospital: 1 
Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 X Yes 2 □ No 2 KER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural
2 Accident Injury 1 Yes 2 No 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 🗍 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 70999 Scotember 6,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 4940 Eastern Avenue, Baltimore, MD, 21224 .32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	ite of Maryland / Depa <i>Cer</i>	artment of He tificate of De			ene g. No. 2012	28849		
Physici		Decedent's Name (First, Middle, Last)  ALONZO E. THOMA	S GILMORE SR.			2. Date of Death Month	er 3 2012	3. Time of Death 12:45 p M		
Med Exami		4a. Facility Name (if not institution, give street a	nd number)	4b. City, Town, or Lo	4		4c. County of Death	1 \		
Funera Director		5. Social Security Number 6. Sec. 1 DM 2	7. Age (In vrs. last birthday)	If Under 1 Year I	5 1 0 WY If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) DEC. 13	(ear) 9. Birtl	nblace (State or Foreign ntry) Y LAND		
<b>A</b>	1	Usual Residence of Decedent  10a, State  10b. County	10c. City, Town or Lo	cation		DEC. 13	1950   MAIX	10d. Inside City Limits		
Marylar 28a-f sl otified	Funeral Director	MARYLAND WASHINGTON		HAGERST	COWN			1 🗆 Yes 2 📈No		
ith the 23a or st be n	ralD	10e. Street and Number 14014 MARSH PIKE		10f. Zip Code 2174	12	10	Og. Citizen of What Cou	untry?		
land 21215-0036  be filed within 72 hours after death with the Maryland ental Hygiene.  ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		11. Marital Status 12. Wa	s Decedent Ever in U.S. ned Forces?	Was Decedent of Hisp f Yes, specify Cuban, I		ify Yes or No- lican, etc.)	14. Race - Amer Black, White			
21215-0036 within 72 hours after giene. er than "natural", o the Medical Exam	ted by	3 Widowed 4XXDivorced If Yes	es, Give ir or Dates.	Yes 2XXNo	Specify:		Specify: BLA	CK		
215-4 n 72 ho an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Seconday (0-12) Col	oleted) (Give i	lent's Usual Occupation  kind of work done duri  O NOT use retired)	on ing most of working	g		. Kind of Business Industry HOUSING & URBAN		
d 21, ed withii Hygiene other th	Be Co	12yrs 17. Father's Name (First, Middle, Last)	AD	MIN. ASST.	8. Mother's Name	(Eirot Middle Mi	DEVELOP			
Maryland 2: 2 should be filed with and Mental Hygic 27 is marked other traumatic event, tt	10	WM FLOYD GILMORE SR.				G. FRED	,			
<u>영</u> 등 등 등		19a. Informant's Name/Relationship (Type, Prin Alonzo E. Thomas Gil	Soli				City or Town, State, Zip	Code)		
. 0		20a. Method of Disposition  1 X Burial 2 Cremation 3 Remov	20b. Place of Dispo	ch Ave., G sition (Name of natory or other place)	7-		• ZIUDI. 20c. Location - City or	Town, State		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once,		4 Donation 5 Other (Specify)  21. Signature notal Service Verses	NATL. HAR	MONY MEMOR			HYATTSVILL			
Dep and			un WI	LLIAM C BF 206 W NORT	ROWN COMM TH AVENUE	UNITY F	UNERAL HOM	E P.A.		
* Dh. aisian		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final	s that caused the death. Do not ente on each line.	0		0	COART!	Approximate Interval Between Onset and Death		
Physician Medical Examiner	1	disease or condition resulting in death)  a. Due to (or as a consequence of):    TIV ENCOPY   CONTROL   CO								
LAGIIIIIei		Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	copha 10	pan	7				
executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c	1-1 T \							
four case be exe	ledical E	resulting in death) Last	Due to (or as a consequence of):							
certificate by nding physic use as the b		IF FEMALE:	es, outcome of pregnancy							
Geath of atterned for u	Physician/N	in the past 12 months?	Live Birth 2 🗌 Fetal death 3 🖺	Ectopic pregnancy Other (specify)	· · · · · · · · · · · · · · · · · · ·		23d. Date of deli Month	very Day Year		
uires that the signed by	à	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
DIVISION Of VITAL RECORDS, P.O., In the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed					24a. Was an autopsy perform	prior to c ed? death?	oppsy findings available ompletion of cause of		
Ital sician: certific irector,	Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{PNo} \) Hospital		Tother:	e of Death (Check	only one)				
O OT V  Jing Phy h.  After this funeral d	ate: To	27. Manner of Death 28a	1 ☐ Inpatient 2 ☐ ER/Outpatier  Date of injury (Month, Day, Year)  28b. Time of injury	28c. Injury at work?	/	ne 5	nce 6 Other (Special National	<u>,                                      </u>		
JIVISION I or Attendate after deat Director:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home, farm, strobuilding, etc. (Specify)			8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,		
Hospita Hospita 24 hours Funeral	Medical	(Check 2 Medical Examiner: On	o the best of my knowledge, death of the basis of examination and/or invest	tigation, in my opinion,	death occurred at t	he time, date and	place, and due to the c	ause(s) and manner stated.		
To the within To the comple	Σ	only one) 3 Ly Certifying Nurse Pract 29b. Signature and title of certifier	ioner: To the best of my knowledge, o	29c. License nu	umber	29	d. Date signed (Month,	Day, Year)		
		30. Name and address of person who complete	mer Cummol	KIDO RIDO	) 170		7/4/2	MO 21742		
2		Stophanic Cunc. 31. Date filed (Month, Day, Year)	- Concordice	ene mon	4 Marsh	n Pilce	Hagerston	MOZINO		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Day Physician/ 20/Year TREEN -15P M DSEPH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Seasons Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 08-20-32 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Country) Director 216-30-0926 80 1 X M 2 D F MD in than "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 No Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 7768 Cornerstone Way 21244 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: American Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Steel Page 1 and 2 should be filed within 72 nent of Health and Mental Hyglene. ant: If Item 27 is marked other than ' College (1-4 or 5+) NA Elementary/Secondary (0-12) Eastern Stainless Machine Operator 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Brown Green George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7768 Cornerstone Way Baltimore, Maryland 21244 Veronica D. Green-Wife Department of H 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State Date 1 D Burial 2 Cremation 3 Removal from State any Injury or 09-18-12 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Li HEROSCLEROTIC EREARO VASCUL Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) siclan and buriai-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician er use as the burial-Physician/Medical Box 68760 attending p yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month been signed by the s should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BLADDER Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autoosy 2 No 1 🗌 Yes 2 No or Attending Physician: 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) HOSPICE ျှင် 2 No 1 🗌 Yes Other: INPATIENT 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th compietely filled in by the funeral 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending Division 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, asheem 28591 nu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 1525 MI 1 ASNEEM WINGS MILL 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:30 P M 9AGKENS hen Sept Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gloria Friends Home Assisted Living Baltimore Essex 8. Date of Birth (Month, Day, Year) Tune 30, 1916 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 214-16-6636 Baltimore, MD Director 1 □ M 2 🏋 F 96 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3027 Balder Avenue 21234 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Benedix Elementary/Secondary (0-12) College (1-4 or 5+) Assembly Line Worker 10 should be filed with and Mental Hygler? permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Harris Gaskins Ellen Carey Wheeley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Dale Boyd-Niece 3027 Balder Avenue, Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Fureral Chapel
Bel Air September 1 Burial 2 XCremation 3 Removal from State Donation 5 Other (Specify) Forest Hill, MD 09, 2012 21. Signature of Funeral Service Licenses Wans Funeral Chapel & Cremetion Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A Physician/ NEIMER disease or condition Medical sulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760° the as attending plant of the last as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performed? death? after death.

Director: After this certificate 1 Tyes 2 II No ☐ Yes 2 **X**No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Assisted Living Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ENN ER

29b. Signature and title of certifier

31. Date filed (Month, Day,

avi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manuel Perez-Bonnelly, MD 1777 Reisterstown Rd. Ste.222 Pikesville, MD 21208

00067680

29d. Date signed (Month, Day, Year)

9,7,2012

State Registrar

legistrar's Signatu 2012

		AMEND 25,27,28A F, Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene										
			1 - State of Marganian	yland / Department of F Certificate of L		ntal Hyglei Reg.	001	2 28853				
	Physicia	an/	1. Decedent's Name (First, Middle, Last)  Jimmie Leroy Gayhart			2. Date of Death	Day 3, 2013	3. Time of Death				
and a	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. Gity, Town, o	r Location of Death	<del>ugust</del>	4c. County of Dea					
X	, 	Р	MedStar Good Samartar  5. Social Security Number 6. Sex 7. Age (Ir	h HOSDITA BOLT I	If Under 24 Hrs. 8	3. Date of Birth	N/A	udhulu a Maada ay Faysiy				
	Funeral Director		217-38-6853 1XM2DF	70 Yrs. Months Days		Mayh, Day, Ya	942 WE	rthplace (State or Foreign				
	and show	١		0c. City, Town or Location				10d. Inside City Limits				
	e Maryl r 28a-f notifie	Direct	MD Baltimore	Baltimore	· · · · · · · · · · · · · · · · · · ·	Т		1 ☐ Yes 2X No				
	with the s 23a o	Funeral Director	15 Belinda Avenue	10f. Zip Code 21 2	206	10g.	Citizen of What Co	ountry?				
	r death	y Fun	11. Marital Status  1	r in U.S. 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, Whit					
21215-0036	urs afte ural", d	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛂 No	Specify:		Specify:	white				
215-(	an "nat Medica	mple	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) Packer	during most of working		o. Kind of Business	· ·				
1212	d withir lygiene ther thant, nt, the	Be Co	Elementary/Seconday (0-12) College (1-4 or 5+)	Packer								
land	l be file fental H rked of tic ever	일	17. Father's Name (First, Middle, Last) William Lercy Gayhart		18. Mother's Name (Fannie	First, Middle, Maid Marjorie	,					
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	9	19a. Informant's Name/Relationship (Type, Print)  Joanne Gayhart-spouse	19b. Mailing Address (Street and a	and Number or Rural R Avenue-B	Number, City altimor	or Town, State, Zi e, Maryl	ip Code) and 21206				
Baltimore,	ge 1 and nt of Hez t: If item or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of Disposition (Name of Evameter) Francisco (10 the polar and Cremation Series	Del Aug.8,		Location - City or					
altin	permit. Page Department of Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee				<u> </u>					
ä	a II De		Condrae L. M. Folde	22. Name and Addres			3 2/234					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Ph. sician/ disease or condition  at HYPOXIC RESPIRATORY FAILURE											
C	Medical Examiner		Due to (or as a co	onsequence of):	MILUKI	<u> </u>		147 6-1-1				
		ner	if any, leading to immediate Due to for as a co	S PLUGGING Disequence of):			11	WEEKS				
	e executed sian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a co		Q	Me	SEDILAL EXAMINER	WEEKS				
0	be exersician a		resulting in death) Last  Due to (or as a co	misequence on:	CERTIFICATI	N APPROVED BY	MEDICAL EXAMINER					
3876	rtificate ling phy e as the	/Med	IF FEMALE:			•						
. Box 68760	• Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Fut hours after death. His certificate has been signed by the attending physici eted filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	☐ Fetal death 3 ☐ Ectopic pregnand	су		23d. Date of de Month	elivery Day Year				
P.O.	s that t gned b be deta		Part II. Other significant conditions contributing to death but n					o the cause of death?				
rds	require been si should I	Completed by	TE COMPRESSION FRACTU		A PLEGIA	1 ∐ Yes 24a. Was an		Probably 4 Tunknown utopsy findings available				
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ital	ician: T certifica ector, p	Be	25. Was case referred to medical examiner?		ace of Death (Check or		110					
of V	g Phys er this eral dir	te: To	27. Manner of Death 28a. Date of injury	28b. Time of 28c. Injury	y at 280	5 Residence  d. Describe how in		cify)				
ion	<b>Attending PP</b> r death. ctor; After they the funeral	Certificate:	2 X Accident Investigation FD 5/28/20	012 UNK M 1 🗆	Yes X □ No PI		MULTIPLE_					
Division of Vital Records,	ital or Al urs after ral Direc		building, etc. (S	ME	₽A	LTIMORE,	MD	ural Route Number, ELINDA AVE				
	To the Hospital or vithin 24 hours after To the Funeral Director of the funeral Director of the filled in birector of the filled in birector filled fille	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam only one) 3 Certifying Nurse Practioner: To the best of my 2 Medical Examiner: On the best of my 2 Medical Examiner: To the best of my 2 M	nination and/or investigation, in my opinio	on, death occurred at the	e time, date and pla	ace, and due to the	cause(s) and manner stated.				
	vithi To #	_	29b. Signature and title of certifier	29c. License	e number	29d.	Date signed (Mont					
	(10)		30. Name and address of posses ho completed cause of death	h (Item 23a) (Type Print)		<i>[-j</i>	ugust	7,2012				
	(0)		EDMUND RAY PANA 50	601 LOCH RAVEN	BLVD,	BALTIN	IDRE, M	10 21239				
	Sta Registra		SEP 11 2012 32 Registrar's	Signature Sales								

NE

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ September Graves Ideal Hazel 2013 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Funeral Days Hours (Month, Day, Year) 217-20-2489 Director 1 □ M 2 🔽 F 87 25 MD 12 10 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 1 X Yes 2 □ No Baltimore MD NΑ 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 21215 2500 West Belvedere Ave Apt 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. If Yes, Give 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) State of Maryland Counselor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ethel Mae Davis Alexander Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 272 Glengary Garth, Glen Burnie, Md 21061 19a. Informant's Name/Relationship (Type, Print) Shelia Freeman-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 9/15/2012 Woodlawn, Md King . Sightule of Funeral Service Licenses տքությում բժջիչ օկնուներ 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that saused shock, or heart dilure. List only one cause on each line used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final myocardial Infarction Physician/ Acute disease or condition Medical resulting in death) Due to (or as a consequence of): 10 years Disease **Examiner** Artery Coronary Sequentially list conditions, Due to (or as a consequence of): Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property is provided by the attending physician and p attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperlipidemic 2 No 3 Probably 4 Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? mellitus piabetes 1 ☐ Yes 2 ☑ No 25. Was case referred to edical 8 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 27. Mann of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) RES - 000 September 05,2018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMURE SINAI KATRINA 4. ABADILLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State varke 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Gary Jerome Genovese September 10:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium 1 Year | If Under Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Director 219-38-3002 70 1 **X** M 2 □ F Yrs 1942 Mar. 10. Maryland Usual Residence of Decedent Show 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland traumatic event, the Medical Examiner must be notified at Director or 28a-f 1 ☐ Yes 2 🔀 No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral , or items 23a 2326 High Point Road 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married within 72 hours after 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than "I Elementary/Secondary (0-12) College (1-4 or 5+) Owner Restauranteur Be Page 1 and 2 should be filed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ျှ James Genovese Dorothy Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 409 Washington Avenue George A. Breschi Suite 600; Towson, MD 21204 / attornev 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 9/10/2012 Towson, MD 21. Signature of Funer 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home. Inc. 23a. Part 1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) PARKINSONS DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown No Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No Yes 2X No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🕱 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred iniury 1 X Natural 5 Pending safter death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

GENOVESE GARY

10:30 p.m.

2012

SEPTEMBER

State Registrar

24 hours a

Medical

29a. Certifier (Check

29b. Signature and tit

JACKIÉ

з **X** 

JONES,

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.
32. Registrati Signature

erson who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM,

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

MD 21093

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brian K. Grim	es		tate of Maryl	and / De	epartmei Ce <i>rtificat</i>	nt of H	ealth and	Menta	al Hygi	<b>are Legib</b> ene		12 2005
Physi	icia	Registrar  1. Decedent's Name (First, Midd	lle,Last)		Certificat	e of D	eatn ———		- 10.5	Reg. N	o. 2U	12 2885
Medical Exa	min	er Brian K Grim	nes							ate of Death lonth Day eptember 4,	Year	3. Time of Death
		4a. Facility Name (if not institution	on, give street and n	umber)		4b. (	ity, Town, or L	ocation of	Death		2012 4c. County of Dea	0757 hrs
		1908 Sommerworth A				В	altimore				to. County of Des	201
Funera Directo		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthd	_	Under 1 Year	If Under 2	24Hrs. 8.	Date of Birth (Mr	M/DD/YYYY) 9. B	Birthplace (State or
		212-90-4338	1 XM 2 F	48	3	Yrs.	onths Days	Hours		Nov. 8,		eign Country) MD
Any		Usual Residence of Decedent 10a. State 10b. County		1100	Oite. To							
<b>*</b>	, ابر	140		106. (	City, Town or							10d. Inside City Limits
urylan	10 2	10e. Street and Number			Balt	imor						1 X Yes 2 No
he Ma	Director	1625 Sexton S	treet			101	Zip Code	1230			tizen of What Cor	untry?
5, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. fram 71 is marked other than "natural", or items 23 arr 288-f she fraumatic event, the Medical Examiner must be movined.			12. Was Dec	edent Ever i	nile la	2.144				US		
death r iten	Financial	1 Never Married 2 Ma	Armed Fo	orces?	J	If Yes, sp	edent of Hispa ecify Cuban, M	nic Origin? Mexican, Pu	? ( Specify ` uerto Rican	Yes or No- , etc.)	14. Race - Ame White, etc.	rican Indian, Black,
after after		1 2 Midound 4 X no	1 Yes orced If Yes, Give Yea	2 <u>X</u> N		1 Yes	2 No :	s necifu:				
hours afte	1 2		ify only highest grac	le completed	) 16a. Dec	edent's Us	ual Occupation	(Give kind	d of work de	one I16h	Specify: W Kind of Business	nite
72 l	Completed	Elementary/Secondary (0-12)	College (1	_	auri	ng most of	working life. D	O NOT use	retired)	1100.	rand of businessi	rindustry
21215-0036 Id be filed within 72 Aental Hygiene. narked other than 'event, the Medical	E	8		0	I M	lason				- 0	Brick 1	Laying
filed filed off	ျပ		•				18.	Mother's N	lame (First,	Middle, Maiden	Surname)	
21215-0036 wild be filed within 7 Mental Hygiene, marked other than e event, the Medical	To Be		rimes					Bet	ty Ja	ne Redn	ond	
MD 11 2 show th and 12 is runnitie	-		-		19b. Ma	ailing Addr	ess (Street a	nd Number	or Rural R	oute Number, C	ity or Town, State	e, Zip Code)
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: Il titem 27 is marked other thinjury are other traumantic event, the Mediuy are other traumantic event, the Medius and the pranamantic event, the Medius and Medius and the Medius and Mediu	1	Kirsten Grimes 20a. Method of Disposition		201	b. Place of Dir	/ Fil	th Ave	nue H			D 21227	
Baltimore, permit. Pages I an Department of Hea mportant: If ites njury nr nther tri		1 Burial 2 X Cremation		m State	crematory of	or other pla	ce)	·	Date	20c.	Location - City or	Town, State
Itin Paritiment International Paritiment International Paritiment International Paritiment International Internati		4 Donation 5 Other Spe 21. Signature of Funeral Service L	cify:	A			matory		p.8,2	012 G1	en Burni	ie, MD
Dep Per i		Of Purieral Service L	idensee	L	2	22. Name a	nd Address of	Facility A	mbros	e Funer	al Home	of Lansdown
Physician	-	23a. Part I. Enter the disease, or c failure. List only one cause o	omplications that ca	ised the dea								MD 21227
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause	Due to (or as a c	Use	of):	rdiov	ascula	r Dis	ease	complic	ated by	Approximate Interval Between Onset and Death
e be executed ysician and burial - transit	al Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c									
be existing and anitial -	edical	X UNPENDED	AMENDED23	a,pt.	11,27,	per m	e,g931	9-18-	-12 sı	n		
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed n.  After this certificate has been signed by the attending physician and infuneral director, page 2 should be detached for use as the burial - transit	S	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, ou	tcome of pre h it at time of d	gnancy 2	Fetal deat	n 3 🗆 E	ctopic preg		23d.	Date of delivery Month Da	ay Year
d by t		Part II. Other significant condition	is contributing to d	eath but not	resulting in th	e underlyir	ng cause given	in Part I	236	Did tobacco u	so contribute to the	ne cause of death?
ires that signed l be deta	d by	Cirrhosis of 1										ably 4 V Unknown
rds requ	ete								- 21	. Was an		ppsy findings available
Records,  The law require ficate has been sig	Completed								-	autopsy performed?	prior to co.	mpletion of cause of
tal Reco		25. Was case referred to medical								Yes 2 No	1 Yes	2 No
of Vital F ng Physician: After this certifi neral director,	o Be	examiner?	Hospital: 1 Inp	atient 2	ER/Outpatie	- 2	26.Place of Do					
n of Viding Physic	-1	27. Manner of Death	28a. Date of	Injury	28b. Time o		28c. Injury at V		ing Home		ce 6 🗸 Other: S	Scene
ion tendir eath. for: A	흲	1 X Natural 5 Pending	(Month, Da	ıy,Year)	}	· injury	1 Yes 2	_	28d. Des	scribe how injury	occurred /	
Division tal or Attendii rs after death. al Director: /	fica	2 Accident Investiga 3 Suicide 6 Could no		f Injury - At h	ome farm str	eet factor	, office buildin	_	201.4			
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	Suicide 6 Could not determine		,,	ome, iaim, su	eet, lactor	, once buildin	g, etc.	or To	etion (Street and own, State)	Number or Rura	Route Number, City
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Div To the Hospital or within 24 hours afte Tu the Funcral Div completely filled in		one) 2 Medical Examin	01. 011 the pasis of 6	xanımation a	ind/or investig	ation, in m	y opinion, deat	u piace, an h occurred	at the time,	e cause(s) and i date and place	manner as stated.	cause(s)
E 2 F 5	ž	29b. Signature and title of certifier	and manner state	su			c. License num				te signed (Month	
		la se An	10 d 12				O.C.M.E.				mber 4, 2012	
	1	30. Name and address of person who	completed cause c	f death (Item	23a)							-
		Carol H. Allan, MD Ass	sistant Medical			Baltimo	re Street, B	altimore	, MD 21:	223		
Sta	ate	B1. Date filed SEP 1, Year 201		rar's Signatu	re							
Registr	वा	AP1 T T CO.	Lanen	w A	May	21						1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 09 9.48 PM GREE ZICKI ATHYOZ Physician/ 04 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MIDDLE RIVER BALTIMORE NURSING Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 233-40-2467 1 □ M 2 🔀 F Director West ViginiA 10-01-1927 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a State be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 Xyes 2 ☐ No BAUTIMORE RIVER Middle 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HELL or items 23a WINDLASS 21220 DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?.

1 Yes 2 No Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates White "natural", 3 ¥ Widowed 4 □ Divorced if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) RESTAURANT MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ FRAUGONLA GILIARIS MAN 19a. Informant's Name/Relationship (Type, Print) GRAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue BACKI MB 21206 . Page 1 and 2 sl ment of Health a tant: If item 27 i ORMEK lebora 20b. Place of Disposition (Name of cemetery, crematory or other place)
Boy View Rematcry 20c. Location - City or Town, State Date 20a. Method of Disposition ₽ <u>=</u> ₽ ☐ Burial 2 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. BALTIMORE IND 09-07-2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 2134 Willow Speing RD F.M.P.A. ASHION 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pl., i ian/ disease or condition resulting in death) Due to (or as a conse ence of): Medical Examiner Sequentially list conditions, Examiner Due to jui as a conse if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and I for use as the burial-transit Bupalon that initiated events Due to (or as a consequence of): resulting in death) Last ptodhe Physician/Medical Hollo the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de by 2 No 3 Probably 4 Unknown Records, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate of completely filled in by the funeral director, pag 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical examiner? Be Other: 2 1410 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D31464

Registrar

6V

SHOAIR

DZIN EUTAW ST Sinte 308 BALTIMORE MD 21261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

. HASHMI

Peten W. Higgins 08/31/2012 1603 PM

			Pleas amo	se Type or Pripend items State of Ma	nt in E 23a,b aryland	Black In	delible Inlue g931 9.	k. Ensure A -11-12 y lealth and k	All Copie Mental Hy	s Are	e Legible.	
		1	State Registrar			Cer	tificate of E	Death		Reg. No	0010	28858
	Di	_	1. Decedent's Name (First, Middle, I	_ast)					2. Date of De Month	ath Da	ay Year	3. Time of Death
	Physicia Medic		Pet	er W.		Higg			August	: 31	, 2012	4:00 p M
	Examin	er	4a. Facility Name (if not institution, g					Location of Death		40	: County of Deatl Ba1	timore
المستهدة	Funeral	1			e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birt	hplace (State or Foreign untry)
	Director		114-40-9092 Usual Residence of Decedent	1 🔀 M 2 🗆 F	63	Yrs.	Worldis	l locate i trains	Sept 1			New York
	show	ö	10a. State 10b. County		10c. City	, Town or Lo	cation	<u> </u>				10d. Inside City Limits
	Maryla 28a-f	Funeral Director	MD Bal	timore		Rei	isterstow	n				1 ☐ Yes 2 🖾 No
	h the	a D	10e. Street and Number				10f. Zip Code	110/		10g. C	itizen of What Co	untry?
	th wit	ie l	5 Sunnydal	e Way	Juan in U.S.	12.1		1136 ispanic Origin? (Sp	ecify Yes or No		U.S.A.	rican Indian
7_	or itel	by Ft	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	Armed Forces?		'	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White	
9	rs afte rral", Exan		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.			I ☐ Yes 2 🛣 No	Specify:			Specify:	White
21215-0036	2 hour	Completed	15. Decedent (Specify only highes		7	(Give		during most of work	ting	16b. I	Kind of Business/	Industry
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d 2	Hygid Hygid Other ent, t	Be (	17. Father's Name (First, Middle, La					18. Mother's Nam	ne (First, Middle	, Maiden	Sumame)	
<u>la</u> n	l be fil fental rked tic ev	은	John	Purce11	Hig	ggins		]	Helen		Wyck	coff
lary	should and N is ma auma		19a. Informant's Name/Relationshi	p (Type, Print)				and Number or Rui				
,ٌ	ind 2 fealth rm 27 her tr	П	Sarah Higgins	Daughter	Tagi B		nnydale W	lay Rei		_	Maryland Location - City or	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mertall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1  Burial 2  Cremation		C	emetery, crei	osition (Name of matory or other place		Date	ļ	-	, Maryland
Ħ	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature - Funeral Service Lie		Can		Cremation  Name and Addre	ess of Facility 11:	5/12 824 Rei			
Ba	Depar Depar Impol any ir		Sephen	m. Y	ant			ERAL HOME				21136
			23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that cause nly one cause on each lin	d the deatl	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
94	nysician/		Immediate Cause (Final disease or condition resulting in death)	_a Reng	1	aller	Ну	pertensio	n			Onset and Death
-	,Medical Examiner		resulting in deathy	Due to (or as			Cardiova	scular Di	92892			
		ner	Sequentially list conditions, in any, reading to immediate	b. Due to (or as			oururova	bediai bi	БСАБС			
	ecuted and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с								
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89	certific nding use as	Σ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy	☐ Ectopic pregnan	·m·		ı	23d. Date of de	elivery
Box 68760	death ne atte ed for	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			Other (specify)				Month	Day Year
P.O.	at the	Phy	9 Unknown  Part II. Other significant conditio	ns contributing to death	but not res	sulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
8, P	Attending Physician: The law requires that the death certificate be executed or death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	d by			_				1 🗆	Yes :	2 □ No 3 □ F	Probably 4X Unknown
ord	v requ	Completed							24a. Wa	s an opsy	24b. Were at	stopsy findings available completion of cause of
3ec	he lav tte has	Ę					-		per	formed?		s 2 🗆 No
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n of	Jing F h. After funer	ate	27. Manner of Death  1 Natural 5 Pendin		ay, Year)	injury	wor	iryat rk? ∐Yes 2∐No	28d. Describe	now inji	ury occurred	
sio	Atten r deat sctor: by the	Į	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At ho	ome, farm, st	reet, factory, office					ural Route Number,
Division of Vital Records,	tal or rs after al Direction			Building, e					City or To			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certificate:	(Check 2 Medical F	Physician: To the best of xaminer: On the basis of Nurse Practitioner: To t	examinatio	on and/or inve	stigation, in my opin	nion, death occurred	at the time, date	e and pla	ce, and due to the	cause(s) and manner stated.
_	vithi Vothi		29b argnature and tile of certifier	C My	2.1	C	29c. Licen	se number		29d. [	Date signed (Mon	th, Day, Year)
	•	0	30. Name and address of person	who completed cause of	death (Iten	n (3a) (Type	Print)	- Luthon	willo.	M	1 210	93
	Sta	ate	31. Date filed (Month, Day, Year)	32 negis	rar's Signa	ature	100	-41-00	(		-	•
	Regist	_	SEP 11	2012 /2 km	n p	3. 400	PL SEE					
DH	MH 17 Rev 06	-ン(111										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28859 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) Date of Death Time of Death Physician/ Sep Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4041 Conowingo Road Lot 57 B Darlington Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Director 218-76-7378 1 XM 2 □ F 54 Sept. 21,1957 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ham maked and injury or other traumatic event, the Medical Examinar must ham maked and injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4041 Conowingo Road Lot 57B 21034 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Bethleham Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Hansen Dorothy Leffers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Lee Hansen/ wife 4041 Conowingo Road Lot57B, Darlington, Maryland 21034 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 99/11/2012 Baltimore, Maryland re of Fundral Service Licensee Stephanie 22. Name and Address of Facilit@remation Society fo Maryland, Inc. Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available 24a. Was an this certificate has ral director, page 2 autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifie completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 08, 2012 Year CAROL MITH HERNDON 08:15P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Powerback Rehabilitation Center Lutherville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months (Month, Day, Year) Hours 062-28-2978 **Director** 1 □ M 2 🗶 F 82 Yrs. 04/02/1930 Virginia 28a-f shov 10c. City, Town or Location 10b. Count **Funeral Director** 10d. Inside City Limits Maryland| Baltimore Lutherville 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Brightfield Road 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc Yes 2XXNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. 'natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Within Hygiene. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) should be file h and Mental h ' is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Carroll Smith Lila Ide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Lila Herndon Vizzard DTR 20th Street North, Arlington, Virginia 22205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) ö Department of Important: If any injury or Metro Crematory 09/11/2012 Baltimore, Maryland ignature of Funeral Se 22. Name and Address of Fach tchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the diseast, or complications, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. nterval Between Immediate Cause (Final disease or condition Physician/ Onset and Death Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Exami use as the burial-tran Due to (or as a consequence of): attending physiciar Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? signed by the at I be detached fo Pregnant at time of death Other (specify) Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform No J Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at the Hospital or Attending of thin 24 hours after death.
The Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes 2 No filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one strifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and t of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sedfember Medical 4a. Facility Name (if not institution, give street an Examiner or Location of Death 4c. County of Death More N/A**Funeral** Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 158-30-9547 Director 1 □ M 2**X**XF 71 12-04-1940 New Jersey en "natural", or items 23e or 28e-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Wicomico Salisbury YXX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29790 Deer Harbour Drive 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ğ 1 Never Married XX Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 Is marked other then " Elementary/Secondary (0-12) College (1-4 or 5+) を Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Finnerty Mary E. Coyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29790 Deer Harbour Drive Salisbury Maryland 21804 Edward A. Harkins Husband Important: If item 2 eny Injury or other I once, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Locustwood Memorial Park XX Burial 2 Cremation 3 Removal from State 09/10/2012 Cherry Hill , New Jersey Donation 5 Other (Specify) Sunature of Funeral Service Licenser 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury Hospital or Attending Physiclen: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 1 ☐ Yes 2 ☐ No 1 Tes filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? <u>(</u>2 2 🗹 No 1 🗌 Yes Other: 1 🗹 Inpatient 2 🗀 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred 1 W Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely The General Projection of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa ure and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Urleans St. B 11 Š 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Howard Hamilton 12:50 P M 2012 September 6, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1315 Morling Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 212-34-7332 Director 1**XX**M 2 □ F 74 July 31, 1938 MD Usual Residence of Decede or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A MD1XXYes 2 □ No r items 23a or ner must be n o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country Funeral U.S.A. 21211 1315 Morling Avenue 12 should be filed within remealth and Mental Hygiene.
The marked other than "natural", or items of 27 is marked other than "natural", an items of 27 is marked other than "natural". 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White, etc. by 1 Never Married 2XX Married 1 Yes 2 No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Johns Hopkins University Campus Police or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Magdalene Johnson ည Albert Sidney Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 1315 Morling Avenue Balto, MD 21211 Sarah C. Holtman (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State Lakeview Memorial Park 9/12/12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 3631 Falls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Monard Physician/ disease or condition resulting in death) 00110 Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician at Physician/Medical Division of Vital Records, P.O. Box 68760 use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page perform this certificate 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes ည 1 Inpatient 2 ER/Outpatient ☐ Nursing Home Residence 6 Other (Specific 28a. Date of injury (Month, Day, Year) Manner of eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

State Registrar

29a. Certifier

29b. Signature and title of certifie

the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HORICHS Physician/ NORMA SENTEMBER Da Year 20/2 17103AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSDI ANDALSTOWN BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr **Funeral** Hours Director 1 □ M 2**X** F 213-03-3740 June 25,1917 95 Maryland permit. Page 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a arminity or other traumatic event; the Marianal Once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott CIty 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 3004 N. Ridge Rd #H-213 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 Secretary Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Pohlman Dorothy Graefe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul N. Horichs / son 905 Berrymans Lane Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Carcemation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/11/12 Woodbine, MD Signature of Foreral Service Licensee Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION ACUTE disease or condition resulting in death) Medical Examiner ATHERO SCLEROSIS Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury -tran that initiated events resulting in death) Last Due to (or as a consequence of) the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Yes 2 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death.

neral Director: After the filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) September 6 2012 054288 5401 Old COURT Rd BAlto, MD 21133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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NORTHWEST HOSPIMZ CENTER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
3:09 PM Physician/ Morth ber Patricia Howell Carra Medical 4a. Facility Name (if not institution, give street and number) County of Dear Town, or Location of Death **Examiner** Anne Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 219-30-6397 1 M 2 X F 02/07/1935 Maryland or 28a-f show be filed within 72 hours after death with the Maryland Ħ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No MD Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 602 Hammonds Ferry Road, Apt. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc. Completed by 1 Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates. White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumating. ပ Lillie Brooks Mae Calahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie L. White / Daughter 756 223rd Street, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 09/07/2012 4 X Donation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signatura of Fune a Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciany disease or condition Medical resulting in death) is a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed -transit and resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year signed by the a 1 ☐ Yes ∠ vo 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 X No certificate 2 X No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 🗌 Yes ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 \( \text{Yes} 5 Pending М I Director: And in by the f 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 00032 Name and address of person who con pleted cause of death (Item 23a) Type, Print) 301

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

			For State	State of		nd / Dep		t of H	lealth :		-	/giene	e 20		288	2 5 5
	Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,	Last)		Cei	incat	5 OI L	Caur		2. Date of De				3. Time of De	
-0	Medical Jean L. Hamill							09 06			06	2012 3:30 P M				
	Examir	ier	Sen. Bob Hooper		oei)				Hill			4	c. County o	of Death irfor	d	
2	Funeral Director		5. Social Security Number  213-38-5730  Usual Residence of Decedent	6. Sex 1 □ M 2 🛣 F	7. Age ( <i>In yr</i> s	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 03/10	ay, Year)		9. Birthp Count	lace (State or Fo	oreign
3:30pm	taryland 3a-f show tifled at	ector	10a. State 10b. County MD Harf	ord	10c. (	City, Town or Lo				, ,				1	0d. Inside City L	
$\omega$	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number  13 Hunter Drive				10f. Zip	Code 210	14				itizen of W	hat Coun	try?	
2012	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1  Yes If Yes, Give Year or Dat	ces? 2 X No		Was Deced f Yes, spec 1  Yes	ify Cuba	n, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e		
_ 47	vithin 72 hour Jiene. er than "natu Ine Medicel	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education		life. D	dent's Usua kind of wor O NOT use S ASS	rk done d retired)	uring mos	t of workin	ng	1	L Kind of Bus partm		ustry Store	
SER 6.	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, La Charles H. Lap			18. Mother's Name (First, Middle, Maiden Surna Evelyn M. Collins					Surname)					
Z a	nd 2 shoul ealth and m 27 is m		19a. Informant's Name/Relationshi Sue Ann Rouzer		er						Route Numbe				ode)	
SEPTE, Baltimore,	Page 1 a timent of H tant: If ite jury or ott		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	3 ☐ Removal from secify)	State	Place of Dispo cemetery, crer e1 Air	natory or o	ther place			ate 2/2012	!	ocation - 0	•	•	
A BE	permit Depart Impor any in		21. Signature of Funeral Service Lie	ensee		22					himunel d., Be					
	Physician/ Medical Examiner	0.00	23a. Part 1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on eac a	h line.	SE CA			_		_	rrest,			Approximate Interval Betwee Onset and Deat	
	be executed visician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse				_							
09/				d		-			_					-		
. Box 6876	law requires that the death certificate as been signed by the attending physe 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outc 1 ☐ Live B 4 ☐ Pregn 9 ☐ Unkno	Birth 2 ☐ Fe auntattime o	taldeath 3	Ectopic p	oregnancy ecify)	/				23d. Date Mont		y Day Year	
17/1ds, P.0	requires that the dea been signed by the a should be detached i	ል	Part II. Other significant condition	s contributing to de	ath but not re	esulting in the u	nderlying o	erfying cause given in Part I. 23e. Did tobacc				2 No 3 Probably 4 Unknown				
#A/H Reco	: The law re icate has be r, page 2 sh	Completed									24a. Was auto perfo 1  Yes		pri de	ere autopoior to correath?	sy findings avail pletion of cause	lable e of
√ of Vital	nysician: The his certificate I I director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	anationt of	☐ ER/Outpatier	. a□ no	Othe	ce of Deat				H.	Hrs.	are ila	u.CL
		Certificate: 1	27. Manner of Death  1 X Natural 2 → Accident Investiga 3 → Suicide 6 → Could no	28a. Date o (Month		28b. Time of injury		Bc. Injury work?	at	21	ne 5 🗆 Resid 8d. Describe h		7	ispeco)	ice pro	u oc
Division	oital or Att urs after d rral Direct illed in by	al Cert	4  Homicide determin	ed 28e. Place of building	g, etc. (Speci					- 1	City or Tow	vn, State	*)		Route Number,	
(g)	the Host ithin 24 ho the Fune ampletely fi	Medical	(Check 2 L. Medical Ex	Physician: To the be arniner: On the basis lurse Practitioner:	s of examinati	on and/or invest	death occu	ny opinior irred at th	n, death oc e time, dat	curred at t	he time date a	and place	e, and due t	o the caus	e(s) and manner	r stated.
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		> 14/w	Cesch	W		17	License	number 1793	2		29d. Da	te signed (	Month, D.	ay, Year)	
	Stat		30. Name and address of person will all the state of the	NES CAA	of death (Ite 23) gistrar's Sign	Dul od	ANCY	/VX	uey	RO	TIMOI	JU	MI	D	21093	
	Registra		SEP 1 1 2	012 2	m f	1. Sar	Kal									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September D 20°12 8:15 A.M Dorothy Jane Hogan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Golden Living Center Westminster If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 188-07-3256 Director 1 □ M 2XXF 92 Yrs Sep. 25, 1919 PA Usual Residence of Decedent 28a-f shov death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 937 Wampler Lane 21158 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ~2 □ No 1945permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3XXWidowed 4 ☐ Divorced Specify: White 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Thomas Odenkirk Vera Scott Wert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick R. Hogan, Sr. (Son) 937 Wampler Ln., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify)
Sonature of Fundance Property of Specify)

Multiple Specify

Multiple Spe Cedar Hill Cemtery 9/10/2012 Brooklyn Park, MD 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr., Manchester, MD 21102 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vance 0 disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months.

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thinknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director; After this certificate has page 2 autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one JX

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Registrar

ss of person who completed cause of death (Item 23a) (Type, Print)

ca heria

32. Registrar's Signature

Kamar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departme	ent of Health and M	lental Hyg		00007		
				te of Death	Re	eg. No. 20   2	28867		
h	Physicia Media		1. Decedent's Name (First, Middle, Last)  Maraget Harmis		2. Date of Death Month	04 2012	3. Time of Death		
1	Examir		4a. Facility Namedif not institution, give street and number) 22 Scuth Green 4b. Cit Wwersty of marykyd medical Center street R	11.		4c. County of Death			
	Funeral			der 1 Year   If Under 24 Hrs.	8. Date of Birth	n/a	hplace (State or Foreign		
	Director		217-22-4095 Usual Residence of Decedent  1 □ M 2 ☒ F 85  Vrs. Month	Year) Cou	yland				
	and show lat	٥	10a. State 10b. County 10c. City, Town or Location		,,-	7	10d. Inside City Limits		
	Maryla 28a-f	irect	MD Baltimore Halethorpe				1 🗆 Yes 2 🏝 No		
	ith the 3a or t be n	la la		Zip Code	11	0g. Citizen of What Cou	Ť		
	ems ?	ted by Funeral Director	419 Caledonia Avenue  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Dec	21227	cify Yes or No-	United St			
9000	urs after de tural", or it al Examine		Never Married 2   Married   1   Yes 2   No	edent of Hispanic Origin? (Spececify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Homem.	ork done during most of workingse retired)	ng	16b. Kind of Business/I	ndustry		
pu	Illed w	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mi	Own home aiden Surname)			
ylar	Menta Menta iarked atic ev	은	Henry Hettling Watts	Mamie					
, Mar	nd 2 shouealth and m 27 is m			ss (Street and Number or Rural donia Avenue Ha					
more,	Page 1 а nent of H ant: If ite ury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Notemetery, crematory or Atlantic Crematory)	other place)	9/2012	20c. Location - City or 3			
Balt	permit. Departr Import any inji			and Address of Facility Amb 1 Sulphur Spring		eral Home			
H			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.	de of dying, such as cardiac or	respiratory arres	t,	Approximate Interval Between		
artany (F	h, i i Medical	i	Immediate Cause (Final disease or condition resulting in death)  a	λ <b>Λ</b>			Onset and Death		
***	Examiner		Due to (or as a consequence of):  Securetially list conditions  by Lentricular Sectal Defenders	ect			48 hr		
-	sit set	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				• • • •		
	ate be executed hysician and the burial-transit	Еха	resulting in death) Last  C. Due to (or as a consequence of):						
09	ite be ( hysicia he bur	dical	d						
687	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent prognant 23c. If yes, outcome of pregnancy						
Box	law requires that the death certificate be executed nas been signed by the attending physician and e 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months?   1			23d. Date of deliv	very Day Year		
s, P.O	res that I signed b d be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		acco use contribute to t			
ord	w requ s been 2 shou	plete	Hupertension		24a. Was an	24b. Were auto	opsy findings available ompletion of cause of		
Re	The ate pag	Completed	Peripheral Vascular Disease						
ta	sician: The certificate rector, pag	Be	25. Was case referred to medical	26. Place of Death (Check of	perform 1 Yes 2 only one)	No 1 L Yes	2 No		
<u> </u>	Physic rthis caral dir	은	1 Inpatient 2 ER/Outpatient 3		ne 5 Residen 8d. Describe how	ce 6 Other (Specif	y)		
ouo	ath. r: Afte	icate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation M	work? 1  Yes 2 No	ou. Describe now	injury occurred			
Division of Vital	sal or Atters as after de al Directo	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office 2	8f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,		
- :	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation, in the control of the death of the control of	my opinion, death occurred at the	he time date and	place, and due to the ca	use(s) and manner stated		
	Vith To to	-		c. License number		d. Date signed (Month,			
			30.;Name and address of person who completed cause of death (Item 23a) (Type, Print)	R115989		4104/201	2		
			Rathyn LWIlliams LONP, 22 South Green St.	Bathmere_mn	21201				
	Stat Registra	e	31. Date filed (Month, Day Year) SEP 1 2012  Again  32. Registre's Signature	1					
	riegiotic		MILL						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28868 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 7, 2012 Thelma Isabelle Howard 10:30 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Transitions Healthcare Sykesville Carrol1 Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 26, 1929 6. Sex 7. Age (In vrs. last birthdav Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2XX Hours Months 82 Yrs Country) **Director** 216-22-9651 Dec. Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 XX Baltimore Reisterstown 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 212 Nicodemus Rd. 21136 U.S.A. ed other than "natural", or items event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important if item 27 is marked other transmy injury or other transmit. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes XX No Specify. Completed If Yes, Give 3 - Widowed 4 - Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Billing Instructor **Utilities** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Dewey Simon Fritz Edna Mae Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Kramb (Daughter) 1611 Heather Heights, Eldersburg, MD 21784 Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Evergreen Mem'1 Grdns 9/11/2012 | Finksburg, MD 21. Si Ature o Funer 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 23a. Fart / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shork, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph, sician/ thewsce ortic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). and that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months?

1 Yes 2 No Month Day Veal be detached 1 ☐ Yes 29 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature/and title of cert 29d. Date signed (Month, Day, Year) 100 Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Westmin 1A HMUUI 2115 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06635 State of Maryland / Department of Health and Mental Hygiene 2012 Edward Hackman 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 2, 2012 1624 hrs Medical Examiner Hack c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of If Under 1 Year If Under 24Hrs. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days Hours Min Months Director 1 M 214-50-30 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 Yes 2 No or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Number 21220 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 No Yes 2 No specify Specify: Give Year 4 Divorced 3 Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natur.
or other traumatic event, the Medical Exami Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 (First Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) 1.A City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation 3 Removal from State Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory **Physician** Between Onset and failure. List only one cause on each line Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED ed by the attending physician detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions has been signed by a 2 should be detached 1 Yes 2 V No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? 2 No Yes 2 No 1 🗸 Yes After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Rider of ATV involved in collision To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A Sep 2, 2012 Certification 1529 hrs 1 Natural 1 Yes 2 ✔ No Pending 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Bird River Road at Cider Court, Middle River, MD Suicide (Specify) Woods Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 3, 2012 O.C.M.E. ess of person who completed cause of death (Item 23a) 30. Name and add

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Jack Titus MD.

Deputy Chief Medical Examiner

34. Registrar's Signat

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Director 1**X** M 2 □ F 61 233-72-8409 WV 10/02/1950 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10h County within 72 hours after death with the Maryland Director Shanks Hampshire 1 Yes 2 No WV 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 26761 USA 196 Jordan Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. à 1 Never Married 2X Married 21215-0036 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced white should be filed within 12 12 and Mental Hygiene.

27 is marked other than "natural marked other than Medical E Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Construction Truck Driver Be Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Channel 17. Father's Name (First, Middle, Last) Emmett Hovatter I and 2 should b F Health and Mer Item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 196 Jordan Way Shanks, WV 26761 Diana Lynn Hovatter Department of Health Important: If item 2. any injury or other t Baltimore, Date unk 20c. Location - City or Town, State
Moatsville WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Locust Grove Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harman Funeral Service 7721 Grayburn Dr Glen Burnie MD 21061 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical disease or condition resulting in death) DENTIFICATION APPROVED BY NEDFOR CHAMINER **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day for Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 No Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 🗌 No certificate 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Be Yes 2 No ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 🗌 Inpatient 2 👤 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 3 Suicide 5 Pending sinale motorcic 29/12 Investigation Place of Injury - At home, farm, street, factory, office building etc. (Specify) 6 Could not be 28f. Location (Street and Number City or Town, State) ROUTE SO ROY 3 ☐ Sulcide 4 ☐ Homicide determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) South breene St Baltimore, MD 21201 AMANDA 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28871 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 nda 0 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2706 21048 Judu Carrol burg Social Security Number If Under 24 Hrs . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Yea 07 01 **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min Director 212-60-5835 Mary land Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amounts if item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 23a or 28a-f shov 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 🔀 Yes 2 🗌 No Carroll MD Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2706 Judy Court 21048 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles DePaola Norma Beatris Walstrum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Ireland / Husband 2706 Judy Court, Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 09/05/2012 | Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Cortico basa disease or condition 2007 Medical resulting in death) Due to (or as a consequence of) **Examiner** 2007 Movement Sequentially list conditions, Examiner If any leading to immediate cause. Enter Underlying Date to for an a consequence of, Cause (Disease or iinjury that initiated events Dementia 2006 burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month signed by the a be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, page 2 should 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe Yes 2 1 🗌 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Descritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D0060465 of person who completed cause of death (Item 23a) (Type, Print) 21093 York Road Laton 31. Date filed (M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Tavares Lonell Jones** State of Maryland / Department of Health and Mental Hygiene 2012 28872 I- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Month Day September 1, 2012 **Medical Examiner** 0217 hrs Tavares Lonell Jones 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital **Baltimore** 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Min Director Months Davs 212-88-5449 38 7/24/1974 Country) 1 X M 2 F M Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show Baltimore MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 I Timber Creek Ct. 21221 USA Funeral 11, Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married Ves Specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ≦ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Tee Bee's Club Security Officer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ William Harris Sr. Linda M. Jones-Carson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jones-Carson-Mother 299 Liberty Rd. #24 Emporia, VA 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 9/10/2012Baltimore,MD Bayview Crematory Signature of Funeral Service Licens 22. Name and Address of Facility March F/H- East E. North Ave. Baltimore, MD 21202 Physician tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Stab Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transi Physician/Medical ysician a burial -UNPENDED X AMENDED #9perFH\_G932\_10/16/2012\_WS Division of Vital Records, P.O. Box 68760, e attending physi for use as the bu 23c. If yes, outco e of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death Ectopic pregnancy Year Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown certificate has been signed by the ector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ē 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical Hospital or Attending Physiciao: 26.Place of Death (Check only one) uneral director, examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other this 1 V Yes 28a. Date of Injury (Month, Day, Year) Sep 1, 2012 After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject stabbed Natural 1 ✓ Yes 2 No Pending Director: I in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 7122 Darlington Drive, Parkville, MD determined (Specify) Bar/tavern 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical To the 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 1, 2012 30. Name and andress of person who completed cause of death (Item 23a) Jack Titús MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State

Registrar

31. Date filed (Month, Day, Year)

alle

32. Registrar's Signatur.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Depart For State Certif	ificate of Death	Reg. No. 2012 288				
in/	1. Decedent's Name (First, Middle,Last)		Date of Death  Mooth  Day  Year				
ner			September 6, 2012 1925 hrs				
	Northwest Hospital	Randallstown	Baltimore County				
	136.91.5342 1×M 20F	t birthday)  If Under 1 Year  Months  Days  Yrs.  Hours  Min.  23	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Poreign Country)				
		own or Location	10d. Inside City Limits				
ъ	MD Baltimore P	Peisterstown	1 Yes 2 No				
	112 Caraway Road	10f. Zip Code 2136	10g. Citizen of What Country?				
nera	1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Richards</li> </ol>					
	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	specify: Black				
ted t		6a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired					
nple	College (14 of 54)	Infant	Infant				
			irst, Middle, Maiden Surname)				
o Be			HOSALIO				
	Gilbert Payne/Unde		y Owing Mills MD 21117				
		ace of Disposition (Name of cemetery,	20c Location - City or Town, State				
	4 Donation 5 Other Specify:		2/2012 Hanover MD				
	21. Signature of Funeral Service Licensee	1 1					
7			espiratory arrest, shock, or heart Approximate Interva				
ı	Immediate Cause (Final disease a. Sudden Unexplai	ined Death In Infancy (	SUDI) Between Onset and Death				
-1	b						
<u>ē</u>	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):						
Kami	(Disease or injury that initiated						
E E	d.	0. 5025 1 25 1					
			23d. Date of delivery				
an'y	3b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregnancy					
Programmer of death street or specific programs and the past 12 months?  If FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) g Unknown							
2	_						
	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?				
줕	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown				
줕	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy prior to completion of cause of				
Completed by			1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No				
Be Completed by	25. Was case referred to medical examiner?	26,Place of Death (Check only	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 Yes 2 No 1 Yes 2 No 1 Yes 2 Yes 2 No 1 Yes 2 Yes 2 Yes 2 No 1 Yes 2 Yes				
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To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation  1 Accident	26.Place of Death (Check only R/Outpatient 3 DOA Other, Nursing R/Outpatient 3 DOA State Nursing R/Outpatient 3 Pool Doal Other, Nursing R/Outpatient 3 Nursing R/Outpatient 3 Pool Doal Other, Nursing R/Outpatient Nursin	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1				
To Be Completed by	25. Was case referred to medical examiner?  1 V Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 2 Suicide 6 K Could not be determined to the service of the	26.Place of Death (Check only R/Outpatient 3 DOA Other, Nursing H8b. Time of Injury 28c. Injury at Work? 28 1 Yes 2 No UT No 1 No	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 N				
Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes	26.Place of Death (Check only R/Outpatient 3 DOA Other4 Nursing H8b. Time of Injury 28c. Injury at Work? 28 1 Yes 2 No UI 1 No farm, street, factory, office building, etc. 28 RC Page 1 No UI 1 No farm, street, factory, office building, etc. RC Page 1 No UI 1 No farm, street, factory, office building, etc. RC Page 1 No UI 1 No farm, street, factory, office building, etc. RC Page 1 No VI 1 No farm, street, factory, office building, etc. RC Page 1 No VI 1 No farm of the farm, street, factory, office building, etc. RC Page 1 No VI 1 No farm of the farm of	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 N				
Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) residen	26.Place of Death (Check only R/Outpatient 3 DOA Other Mursing Hab. Time of Injury 28c. Injury at Work? 28 1 Yes 2 No UI 1 No Le, farm, street, factory, office building, etc. 28 No LCC Reach occurred at the time, date and place, and du	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 N				
edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending Investigation 3  Suicide 6  Could not be determined  (Specify)  Pesiden  29a. Certifier 1  Certifying Physician: To the best of my knowledge, one)  2  Medical Examiner: On the basis of examination and/or summer of the summer	26.Place of Death (Check only R/Outpatient 3 DOA Other Mursing Hab. Time of Injury 28c. Injury at Work? 28 Yes 2 Yes No UT 1 Yes 2 Yes No UT 28c farm, street, factory, office building, etc. 28 Yes death occurred at the time, date and place, and durinvestigation, in my opinion, death occurred at the 29c. License number	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No yone)  Rome 5 Residence 6 Other:  1 Describe how injury occurred nknown  1 Location (Street and Number or Rural Route Number, City or Town, State) 112 Caraway Rd. Apt 1 Reisterstown, MD.  1 et ot the cause(s) and manner as stated.  1 te time, date and place, and due to the cause(s)				
edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) residen  29a. Certifier 1 Certifying Physician: To the best of my knowledge, and manner stated.	26.Place of Death (Check only R/Outpatient 3 DOA Other,4 Nursing F 28c. Injury at Work? 28 1 Yes 2 No UT 1 Yes 2 No UT 28c. farm, street, factory, office building, etc. 28c. death occurred at the time, date and place, and du 29c. License number O.C.M.E.	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  4 yone)  4 one 5 Residence 6 Other: 4 Describe how injury occurred  5 Residence 6 Other: 5 Residence 6 Other: 6 Describe how injury occurred  6 Namber or Rural Route Number, City or Town, State) 112 Caraway Rd. Apt 12 Caraway Rd. Apt 12 Ceisterstown, MD.  6 to the cause(s) and manner as stated.  7 lee time, date and place, and due to the cause(s)				
edical Certification: To Be Completed by	25. Was case referred to medical examiner?  27. Manner of Death  1 Natural 5 Pending Investigation Accident Investigation Suicide 6 Could not be determined (Specify) residen  28a. Date of Injury (Month, Day, Year) fd 9-6-12  28e. Place of Injury - At home (Specify) residen  29a. Certifier 1 Certifying Physician: To the best of my knowledge, and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23)	26.Place of Death (Check only R/Outpatient 3 DOA Other,4 Nursing F 28c. Injury at Work? 28 1 Yes 2 No UT 1 Yes 2 No UT 28c. farm, street, factory, office building, etc. 28c. death occurred at the time, date and place, and du 29c. License number O.C.M.E.	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  4 Onescribe how injury occurred  1 Cocation (Street and Number or Rural Route Number, City or Town, State) 112 Caraway Rd Apt 11  25 Eisterstown, MD et impediately and manner as stated.  1 29d. Date signed (Month, Day, Year)  September 7, 2012				
Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  27. Manner of Death  1 Natural 5 Pending Investigation Accident Investigation Suicide 6 Could not be determined (Specify) residen  28a. Date of Injury (Month, Day, Year) fd 9-6-12  28e. Place of Injury - At home (Specify) residen  29a. Certifier 1 Certifying Physician: To the best of my knowledge, and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23)	26.Place of Death (Check only Produpation 1 3 DOA Other    8b. Time of Injury 28c. Injury at Work? 28    1 Yes 2 No UI    1 Ace Redained the time, date and place, and du    29c. License number    29c. License number    20c. M.E.	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  4 Onescribe how injury occurred  1 Cocation (Street and Number or Rural Route Number, City or Town, State) 112 Caraway Rd Apt 11  25 Eisterstown, MD et impediately and manner as stated.  1 29d. Date signed (Month, Day, Year)  September 7, 2012				
	ician/Medical Examiner To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last)	10. Decodent's Name (First, Middle, Last)  10. Social Security Number (First, Middle, Last)  10. State (First, Middle, Last)  10. State (First, Middle, Last)  10. State (First, Middle, Last)  11. Martial Status (First, Middle, Last)  12. Was Decedent Ever in U.S. (First, Middle, Last)  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri (First, Middle, Last)  13. Was Decedent's Usual Occupation (Give kind of wordering most of working life. Do NOT use retired during most of working life. Do NOT use retired turning most of Deposition (Name of cemetery, crematory or other place)  13. Informant's Name/Relationship (Type, Print)  13. Martial Status (Street and Number or Run (First, Middle, Last)  14. Donation 5 Other Specify  25. Specify (Dasa, Merical)  15. Decodent's Education (Specify only highest grade completed)  16. Decodent's Usual Occupation (Give kind of wordering most of working life. Do NOT use retired during most of working life. Do NOT use retired during most of working life. Do NOT use retired for the print of the death of Disposition (Print Specify)  20. Place of Disposition (Name of cemetery, crematory or other place)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Value (County Mark)  23. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as bardiac or refailure Light only one cause on each line.  15. June County (First Underlying Gausse)  16. Due to (or as a consequence of):  25. Due to (or as a consequence of):  26. Due to (or as a consequence of):  27. Due to (or as a consequence of):  28. Due to (or as a consequence of):				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4, Physician/ ROBERTA 2012 BERNICE KYLE 3:00 A. M Medical Facility Name (if not institution, give street and number)
Larkin Chase Nursing and
Rehabilitation Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1939 (Month, Day, Year) 18, September 18, . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours 579-52-2837 **Director** 72 Tennessee 28a-f show 10b. County 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Capitol Heights 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1109 Adeline Way 20743 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) District of Columbia id Mental Hygiene. marked other than entary/Seconday (0-12) College (1-4 or 5+) 11th grade Police Department Custodian Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest **Kyle** Carrie Simpson t. Page 1 and 2 should be trent of Health and Mer tant: If item 27 is mark jury or other traumation 19a, Informant's Name/Relationship (Type, Print) & William Earl Kyle (Son) & 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Mae Kyle Lonon (Sister) 5707 - 9th Street, N.W.; Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sept.14,201 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral S Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 M01421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 5 Other (specify) signed by the a 9 X Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2**X** No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 **X** No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending neral Director: A ifilled in by the fi 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 5, 2012 D45217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 Greenbelt Road; Suite M-18 Adebowale Isaac Ajayi, M.D. College Park, Maryland 31. Date filed (Month, Day, Yea 32. Registrarts Signatur

DHMH 17 Rev 7/2009

State

Registrar

SEP 1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard David Kinsey September Day 2012 6, 5:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Manor Care-Towson Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 🗆 F Months Days Hours Year) 1925 192-14-7388 87 March 18 Country) Director Fairview. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The filem 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville Maryland 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9931 Nearbrook Lane 21234 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Worker 12 General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Kinsey (Spouse) 9931 Nearbrook Lane Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pi permit. Page 1 a
Department of H
Important: If ite
any injury or otf 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State September 08, Evans Funeral Chapel-Bel 4 ☐ Donation 5 ☐ Other (Specify) 2012 Forest Hill, Maryland Signature of Funeral Service Licensee Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Dav 2 No n signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? has been sign 1 Yes 2 No 3 Probably 4 Vinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed

Yes 2 certificate ! 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Tes 2 No Other; After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours

To the Funeral I

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

X

30. Name and address of person who

thom Woods Ste 20, MD 2123G.

completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28876 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3:21 QM John J. Kavanagh, Jr. 09 2012 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ROSEDALE FRANKLIN SQUARE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 3, 1962 9. Birthplace (State or Foreign **Funeral** Hours 212-58-5174 Maryland 50 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Harford County Maryland Abingdan 10g, Citizen of What Country? **United States** 10e, Street and Number Zip Code ems 23a or r must be r 21009 6 Kensington Parkway Funeral items 2 . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces?
1 Yes 2 No Black, White, etc þ 1 Never Married 2X Married KAVANAGH, JOHN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Joseph Kavanagh Company President 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernardine Crew 2 John J. Kavanagh, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Kensington Parkway, Abingdon, Maryland 21009 Nancy Kavanagh (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Majorial Cardens Sept. 10,2012 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner COAGULOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury A BOOMINAL MASS burial-tran that initiated events resulting in death) Last nding physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 🔼 No 3 🗌 Probably 4 🔲 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? 1 X Yes 2 No certificate 1 X Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be 1 X Yes 2 🗌 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work?
1 \( \sum \) Yes 2 \( \sum \) No 1 X Natural 5 Pending iniury Accident
Suicide Investigation 6 Could not be

or Attending Physician; The law requires Division of Vital n 24 hours after death.

le Funeral Director: After oletely filled in by the fur Hospital

completely within 2 To the F

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) De DAS, GOPIMOHAN

determined

**RES**0000

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 09,06,2012

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

SQUARE DR. BALTIMORE MD 21237 9000 FRANKLIN

29b. Signature and title of certifier

4 Homicide

29a. Certifier

(Check

only one

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				e of Maryland / Dep			giene 2012	28877
			State Registrar	Ce	ertificate of Deat		Reg. No.	. 20011
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	E KONE		2 Date of Dea	E 31 adera	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and in MCD)		4b. City, Town, or Locati		4c. County of Death	John
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Date of Birt	th 9. Birth	place (State or Foreign
	Director		216-38-0482 1 □ M 2 🗵 Usual Residence of Decedent	71 Yrs.				ryland
	ith with the Maryland ms 23a or 28a-f show must be notified at	tor	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	e Man 28a- notifie	Director	MD Washington	Hagersto				1 X Yes 2 No
	/ith th		10e. Street and Number	. 1	10f. Zip Code	1	10g. Citizen of What Cou	ntry?
	death v items	Funeral		ecedent Ever in U.S. 13.	21740  Was Decedent of Hispanic	Origin? (Specify Yes or No-	U.S.A.	can Indian
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Y	Forces? les 2 🔀 No	If Yes, specify Cuban, Mexital Yes 2 X No Specific No. 1	tican, Puerto Rican, etc.)	Black, White,	,
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ylar	ld be f Menta arked atic ev	오	William Morris		Ac	delaid W	eaver	
Mar	shou h and 7 is m	1	19a. Informant's Name/Relationship (Type, Print)			mber or Rural Route Number		Code)
.e.	and 2 s Health tem 27 other tra		Richard Morris / Son  20a. Method of Disposition	20b. Place of Disp		Stevensville,	MD 21666 20c. Location - City or T	The Charles
mol	age 1 ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 🔀 Donation 5 ☐ Other (Specify)	om State cemetery, cre	ifts Registry		Hanover, Ma	
Baltimore,	permit. Popartm Departm Importa any inju		21. Signatur of Fundal Service Diversee	2	22. Name and Address of Fa		Gifts Regist	ry
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687	eath certifica attending ph for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy			CON Data of data	
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transical process.	Completed by Physician/Me	in the past 12 months?	ive Birth 2  Fetal death 3 regnant at time of death 5 nknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Day Year
ls, P.O.	uires that in signed build be det	ed by P	Part II. Other significant conditions contributing t	o death but not resulting in the	underlying cause given in P		obacco use contribute to t	
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Re	nysician: The law I nis certificate has k I director, page 2 s	Con					ormed? death?	
ita	sician certifi irector	m	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	~		Death (Check only one)		
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Ou	ending sath. or: Afti	ficat	2 Accident Investigation	fonth, Day, Year) injury	work? M 1 ☐ Yes 2	1		
Division of Vital Records,	To the Hospital or Attending Phyvithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certificate:		ace of Injury - At home, farm, st ilding, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or Rura n, State)	l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physician: To th	e best of my knowledge, death	occurred at the time, date a	and place, and due to the ca	ause(s) and manner as sta	red.
	the Ho hin 24 the Fu npletel	Med	(Check only one) Medical Examiner: On the Control o	basis of examination and/or inve- ner: To the best of my knowledge	stigation, in my opinion, deatl	th occurred at the time, date as	ind place, and due to the ca	use(s) and manner stated
	70 wit		29b. Signature and the of certifier		29c. License number	er /	29d. Date signed (Month,	(Day, Year)
			30. Name and address of person who completed c	ause of death (Item 23a) (Type,	Print)	A1- 10	et li	1 00
	- 0-		M. A. BLSAN M.V. 31. Date filed (Month, Day, Year)	Actistrar's Signature	TO Meik	1 Mena) (6	We have	Nawy M
	Stat Registra	•	SEP 1 1 2012	Remarks a signature	ale			/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28878 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 123 Riviera Drive Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 219-26-8388 1 XM 2 □ F Yrs. 74 06/28/1938 Maryland Usual Residence of Decedent items 23a or 28a-f shorer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 Riviera Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò ۶ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: Completed 3 Divorced Specify: Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) if Health and Mental Hygiene.
item 27 is marked other that
other traumatic event, the N College (1-4 or 5+) 12 Shipyard Laborer Shipyard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pege 1 and 2 should be Elmer John Kreczmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 123 Riviera Drive, Pasadena, MD 21122 Karen Kreczmer / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ò 1 Burial 2 Cremation 3 Removal from State Depertment of Important: If any injury or 09/07/2012 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immedia cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami The law requires that the death certificete be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1- Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nichnez NTA M 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day FELICIA, R, KENDALL 17.40 M 08 2012 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City BALTIHORE, GOOD SAMARTTAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 08/23/1940 Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F 219-38-0026 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d Inside City Limits MD Forest Hill Harford 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1704 Rich Way 1A 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Marshall Genevieve T. Marhefka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Kendall - Son 319 Hunters Run Dr., Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 1 X Burial 2 ☐ Cremation 3 □Removal from State Holy Rosary Cemetery 09/13/2012 Baltimore, MD 4 ☐ Dona**/f**on 5 ☐ Other (Specify) 21. Signatur of Funeral 22. Name and Address of Facility 610 W. MacPhail Rd., Bel Air, Md., 21014 Schimunek Funeral Home 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATIC ENCEPHALOPATHY Due to (or as a consequence of): ACUTE LIVER FAILURE Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

**Physician** /Medical Examiner

that the death certificate be executed

P.O. Box 68760

Division or Vital Records,

or Attending

death.

hours after

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important; If item 27 is marked other if any Injury or other traumatic event, the

**Physician** 

/Medical

Examiner

Funeral

**Director** 

23a or 28a-f show

'naturai", or items

Medical Examiner must be notified at

the

Director

Funeral

þ

Completed

Be

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner and burial-tran physician Physician/Medical the attending asn į ed by the a detached f signed b I be deta by Completed peen has page 2 certificate Be P this funeral After t Director: filled in by

hin 24 hours a 0 10 V

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

09/08/2012

V.Manasa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., MANASA VULCHI BALTINORE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

RESOOD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28880 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Eileen Honore Kerr 7:30  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate House - Hospice Of The Chesapeake Linthicum Anne Arundel 5. Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛚 Months Days Min (Month Pay Year) 41 Pennsylv<u>ania</u> 195-34-0686 71 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 □ No MD Anne Arundel Annapolis 10e. Street and Number must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 930 Bay Forest Court, Apt. 301 21403 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner n 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify. White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Benefits Administrator Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James Miller Marianne Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Jones / Daughter 1388 Stonecreek Road, Annapolis, MD 21403 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Chesapeake Crematory 9/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) ţ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? After this certificate 2 1 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred House 5 Pending 1 🗌 Yes 2  $\square$  No within 24 hours after death. **To the Funeral Director:** A filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of oertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

2012

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 2931 9-11 12 and Mental Hygiene State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:00 AM Medical 4a. Facility Name (if not institution, give street and number) Rosedale, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shirleybrook Ave MD21237 Bullimore Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F 217-52-6699 Director Usual Residence of Decedent 28a-f show 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Middle Baltimore MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 Hydroplane Drive USA permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 If Yes, Give 1 Tyes 2 No Specify White Completed 3 Divorced Specify: Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disablea disabled Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Joseph Nancy iavi a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James King brother Middle River, MD 21220 Hudroplane Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bauview 0/12 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) Crematory! . Signature of Fugeral Service Licens 2134 Willow Spring Rd Durdalk 23a. Part 1. Ententitle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Funeral Home P.A MD 2122 Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 0 cco und Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin d be detached for use 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death?

1 Yes 2 No autopsy perfor Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No Hospital 1 Tes Other: မ mother's 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 6 X Other (Spec 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) residence Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to t e(s) and manner as stated. 29d. Date signed (Month. Dav. Year) 2012 7221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WI

State

Registrar

31. Date filed (Master

Régistrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 4. Sheila Monaghan 7:15 P M Kennedy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 222-40-6047 **Director** 1 □ M 2X F 59 Feb.7, 1953 Delaware Usual Residence of Decedent 28a-f shov Hygiene. other than "natural", or items 23a or 28a-f shov other than "natural", or items 23a or 28a-f shov 10b. County 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 Yes 2X No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 A Osborne Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital and Mental Hygie is marked other event, Be 2012 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Monaghan Verna Gasser 4, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important; If item 27 is any injury or other trau William Kennedy- Husband Osborne Avenue, Catonsville, Maryland 21228 SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lorraine Park Cem. 9/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 46 M0123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be SHELIA KENNEDY IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12\_ Pregnant at time of death Month Day Year 2 🗶 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Yes 2 **X** No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the 24 hours after deat Funeral Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one Certifying Nurse Practitioner: To the heat of my kno 29b. Signature and title of certifier 29c. Ligense number

Registrar

DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**CRNP** 

TRACIE L, MORGAN,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PII, 25, 27, 28A-F, PER ME G931 9/5/12 TRT

State of Maryland / Department of Health and Mental Hygiene 2 1 2 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7!09 P M Physician/ John W. Lang Jr. 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. County of Death seda quare 0 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months 213-28-3194 83 Director 1**X** M 2 □ F June6,1929 MD iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 339 Dark Head Road 21220 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Lang, John Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married 1 Yes 2 No Specify: White If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Bricklayer 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname John W. Lang Clara Rotherbucher 19a. Informant's Name/Relationship (Type, Print)

Robin Meyer /daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2470 E. Burdie Lane Orange CA 92869 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/21/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 300 Mace Ave. Balte Connelly Funeral Home of Essex Balto. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) monas Pneumonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine CENTERCATIO APPROVED BY MEDICAL EXAMI resulting in death) Last attending physician Physician/Medical as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnam 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Kidney Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RIGHT PNEUMOTHORAX 24a. Was an page 2 autopsy performed? Yes 2 No certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natoral 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the form 2 XAccident 2 **X** No Investigation 7/28/2012 SUBJECT FELL UNK 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 339 DARK HEAD ROAD MIDDLE RIVER MD determined HOME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08.16.2012 duna 30. Name and address of person who completed cause Dr. Asima Rahman of death (Item 23a) (Type, Print) Franklin Square Dr. Balto, MD, 0123 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28884 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ SEPTEMBER 10, 2012 Bernard 2:10 A Jay Land Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON TIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 219-60-3642 Director 1 X M 2 □ F 53 31. 1959 Marvland 10b. County 10c. City, Town or Location should be filed within 72 hours efter death with the Maryland Item 27 is marked other then "natural", or items 23a or 28a-f sho other traumatic event, the Medical Example of mast to mother at 10d. Inside City Limits Director Maryland Baltimore 1 🗆 Yes 2 🔯 No Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13004 Talisman Road 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🕅 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 years Elementary/Secondary (0-12) Sales Manager Beverage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Land Miller Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health en Important: If Item 27 Is any injury or other trau Page 1 end 2 June G. Land 13004 Talisman Road Reisterstown, Maryland 21136 (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9-11-12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of):

ARDIO RESP Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the deem certificate we executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Vear 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PNEUMONIA 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of-certifier 29d. Date signed (Month, Day, Year) 31826 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 31. Date filed (Month, Day, Year) SEP 1 2012 22. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 28885 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>12:3</u>2 A<sup>™</sup> September Lenore Hoffman Loock Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 217-24-3922 1 □ M 2 🗓 F Yrs. 84 March 20,1928 Maryland r then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County deeth with the Merylend 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Road 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by Pege 1 end 2 should be filed within 72 hours efter ment of Health and Mentel Hygiene. ent: if Item 27 is merked other then "neturel", or ury or other treumetic event, the Medical Exami 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: If Yes Give 3 Divorced 4 Divorced Specify: Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 04 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lerov Hoffman Harvey Estelle Christine Heimert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry W. Loock, Jr./Husband 12261 Roundwood Road, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/10/2012 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. permit. Pege Department of Importent: if eny injury or once. 4 Donation 5 Other (Specify) Valley Memorial Gardens Dulaney Timonium, Maryland Manutur 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or complication shock, or head foliume. List only one cause s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Caus (F) all disease or condition Priysician/ emic years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physicien: The lew requires thet the deeth certificate be executed ettending physicien end I for use es the burial-trensit Cause (Useass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 4 Pregnant at time of death Year After this certificete hes been signad by tha e stunerel director, page 2 should be detschad 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes 8 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🔀 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA hospul \_4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury iours effer daeth. Ierel Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel of 24 hours er Medical To the Hosp within 24 hou To the Funel completely fl 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness as a scale.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M HAVVES 6701 31. Date filed (Month, Day, SEP 1 1 32. Registrar's Signatu Registrar

			. For	Type or Print in State of Maryla						gible.	
			1 - State Registrar		Ce	rtificate (	of Death		Reg. No.	2012	2888
	Physici /Medic		1. Decedent's Name (First, Middle, La. Roy L	vebbe				2. Date of D Month O9	Day 06	Year 2012	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution, giv			4b. City, Tow	n, or Location of I	Death	4c. Cour	nty of Death	
and the	-		Oak Crest Villa  5. Social Security Number 6. S		rs. last birthday)	Park	<b>ville</b> ear   If Under 24	Hrs. 8. Date of B		Baltimo	re e (State or Foreign
	Funeral Director			⊠м 2□ F 83	Yrs.			Min. (Month, E	Day, Year) 12,1929	Country	vlvania
	ס		Usual Residence of Decedent					Whiti	12,1925	renns	sylvania
	ryfan thow	_	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d.	Inside City Limits
	8a-f s	Director	Maryland Baltimo	re	Parl	kville					1 ☐ Yes 2 🂢 No
	/ith th	Dir.	10e. Street and Number			10f. Zip Co	de		10g. Citizen o	of What Country	?
	I within 72 hours after death with the Maryland gene. r than "natural", or items 23a or 28a-f show the Modical Examiner must be rodified at	eral	8820 Walther Blv			212				USA	
	item item	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 [X]Yes 2 ☐ No	U.S.   13.	Was Decedent If Yes, specify	of Hispanic Origii Cuban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	Io- 14. H	lace - American lack, White, etc.	
36	irs aff	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🔀	No Specify:		Spec	cify: Whi	<b>t</b> 0
21215-0036	2 hou	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual O	ccupation		16b. Kind of	Business/Indus	
215	within 7, iene. than "n	ple	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work de DO NOT use re	one during most o etired)	f working	Sch	ool of	
	filed with Hygiene. other than	5	12	n/a	I	Directo	r			ineerin	g
nd	a la	Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middl	e, Maiden Surn	ame)	
<u>Y</u>	should be and Mental s marked o	ျ	L. William				He1		atherin		ailey
Maryland	is a		19a. Informant's Name/Relationship (	-		•		or Rural Route Num			,
	1 and Health em 27 ther ti		Susan Marie Luebb 20a. Method of Disposition					, Sparks,		nd 211 n - City or Town	
JO.	Pages nent of ant: If It		1 ☐ Burial 2 🛣 Cremation 3 🗆	Hemovai from State	p. Place of Dispo cemetery, cre					,	,
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Decination 5 ☐ Other (Specifical Service Licer	/ /	lantic	2 Name and A	ddress of Facility	/10/12			Maryland_
Ba	Depart Impo		Bryan W. Clary	Clays	, I	Lemmon 1	Funeral	Home of Doad, Timo	ulaney nium, M	Valley D 21093	Inc.
-	Physician		23a. Part1. En er the disease, or com shock, o heart frillure. List only Immediate C use (Phal disease or con itton	one cause on each line.				ardiac or respiratory		l In	pproximate iterval Between inset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):						
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						
	icate be executed physician and the burial-transit	am	that initiated events resulting in death) Last	C				· · · · · · · · · · · · · · · · · · ·			
60,	cial		rooding in doday, zaot	Due to (or as a cons	equence or):						
68760	certificate nding physise as the t	dici		d							<del></del>
O. Box	atter for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1  Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	⊒ Ectopic pregi ⊒ Other <i>(specit</i>				Date of delivery Month Da	ay Year
σ.	that led b		Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	inderlying cause	e given in Part I.	23e. Dio	tobacco use co	ontribute to the	cause of death?
ds	95	d by						1	Yes 2 No	3 ☐ Probab	ly 4 □ Unknown
Vital Records,		Completed						24a. Wa	s an 24	h Were autons	y findings available
Re	The law ate has t	m d		<del></del>				— aut	opsy formed?	prior to comp death?	letion of cause of
ta	iclan: The certificate ector, pag	ပိ	25. Was case referred to medical				GE Place	1 □Yes of Death (Check only	2 <b>7</b> No	1 □ Yes 2	□No
>	Physician: this certific al director, p	O.	examiner? 1 ☐ Yes 2 📜 No	Hospital: 1   Inpatient 2	☐ EB/Outpatie	nt 3□ DOA	Othor:	sing Home 5 Re		Other (Specify)	
οl		H= ∪	27. Manner of Death	28a. Date of Injury (Month, Day, Year,	28b. Time o		Injury at Work?		how injury occ		
jor	Attending it death. ector: Afte by the fune	atio	↑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	anjury		work? 1 ☐ Yes 2 ☐ No	,			
Division	al or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st	reet, factory, off	fice		(Street and Nu own, State)	mber or Rural R	Noute Number,
	ne Hospital or Att n 24 hours after de ne Funeral Directo pletely filled in by t	dical	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at to	he time, date and my opinion, death	place, and due to the occurred at the time	ne cause(s) and e, date and plac	manner as stat e, and due to th	ed. ne cause(s)

State

29b. Signature and title of certifier

29c. License number H 0052365

29d. Date signed (Month, Day, Year) 09-07-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Jeffreys 880 Walther Boulevard, Parkville, Maryland

31. Date filed (Month, Day, Year)

32. Regignar's Signature

SEP 1 2012 21234

Registrar

12-06791 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jason David Leonard State of Maryland / Department of Health and Mental Hygiene 2012 28887 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day September 8, 2012 **Medical Examiner** 0341 hrs David Jason Leonard 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Right Wing Drive and Right Aileron Street **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 219-08-3741 XXM 2 F 8,1985 27 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County s 23a or 28a-f show e notified at once. 28a-f show Limore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiene, "attent of Health and Montal Hygiene," or items 23a or 28a-f sho trant: If tien 27 is marked other than "natural", or items 23a or 28a-f sho withor tranumatic event, the Medical Examiner must be notified at once. Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  $\bar{\Box}$ 21085 United States 1808 Philadelphia Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married Yes If Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl 12 Years Laborer Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Madeline C. Joynes Glen Pullen ဥ 19a. Informant's Name/Relationship (Type, Print) 1808 Philadelphia Road Joppa, Maryland Madeline C. Joynes (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore. 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Department of 9/13/2012 Hilltop Service Corp. Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit sician/Medical UNPENDED AMENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phys Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performed death? Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene Inpatient ER/Outpatient 3 DOA **✓** Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Sep 8, 2012 Pedestrian struck by auto 1 Natural 5 Pending Yes 2 V No the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be

If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Country) MD 10d. Inside City Limits 1 Yes 2 No 14. Race - American Indian, Black, White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Towson, Maryland Approximate Interval Between Onset and Death Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital nr Attending Physician: within 24 hours after death.

To the Funeral Director: completely filled in by 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) Right Wing Drve and Right Aileron Street, Middle River, (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 8, 2012 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed SEP 82. Registrar's Signature Barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1, per phy 931 9-28-12 sm State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Agnes Hazel Lurz 2. Date of Death Physician/ Agnes Hazel 2012 12:30 A.M September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5, **Funeral** 9. Birthplace (State or Foreign Days Hours Director 219-12-5944 1 M 2XX 88 Baltimore, Maryland 1924 or 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Timonium Baltimore Maryland 1 Yes 2 XNo 10e. Street and Number ŏ 10f. Zip Code pe 10g Citizen of What Country?
United States 21093 must be Funeral 2300 Dulaney Valley Road of America items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or ite the Medical Examiner Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after white 1 Yes XX No Specify: 3 Widowed Divorced Completed 12:30 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other t 2012 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မ Henry J. Lurz Pauline Nash ထ် 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mr. Howard L. Carper/son 1 Broadbridge Road Rosedale, Maryland 21237 SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September Evans Funeral the place) Chapel – Bel Air 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10, 2012 Signature of Moneral Service Licen Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ng physician and as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 AGNES LURZ IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ fo in the past 12\_ Month Dav Year signed by the at Id be detached for Pregnant at time of death Yes 2 X No 1 Yes 2 1 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hospital or Attending Physician: The law requires Division of Vital Records, Completed 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy this certificate Yes 2 X No funeral director, 25. Was case referred to medica B 26. Place of Death (Check only one) examiner? 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural work? 5 Pending 2 🗌 No Investigation 6 Could not be Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title

State Registrar 30. Name and ad

JACKIE JONES,

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

erson who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 8, 2012 Physician/ R. LOMAX 3:15A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON RINCE GEORGE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 578-70-0911 Director 59 1 □ M 2XXF Yrs 2/2/1953 WASHINGTON, DC Usual Residence of Decedent th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notifled at</u> 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 □ No PRINCE GEORGE FT. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9012 PINEHURST DR 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 X Married ۾ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify:BLACK If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE OFFICE MANAGER 12th Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ HORTENSE BAYLOR RANDOLPH LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. AARON H. LOMAX/HUSBAND 9012 PINEHURST DR FT. WASHINGTON, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State RIVERDÁLE CREMATORY RIVERDALE, MD 9/11/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Livensee 474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) 1 Yes 2 9 Unknown To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER ay CHARLES VINTON LUCAS 4 2012 4:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 577-74-2412 57 1 X M 2 □ F **Director** Yrs. JAN 4 1955 WASHINGTON, DC 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1425 1st STREET SW # 11 20024 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural" and item. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2x No Specify: 3 Widowed 4 Divorced BLACK Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) SHEET METAL PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ည MATTIE MAE WALKER EDGAR M. LUCAS JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 BOHAC LANE ACCOKEEK, MARYLAND SHARON ROSS/SISTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State RIVERDALE MARYLAND 9/8/2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature June al Service Licenses J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph,si∟ian/ Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami use as the burial-transi that initiated events resulting in death) Last nding physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death been signed by the a should be detached Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 10 Other: 1 🗌 Yes 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of

offress of person who completed cause of death (Item 23a) (Type, Print)

License number

heverly mo 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ SEPTEMBER 4 2012 MINDR KYMELYN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMOREC BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Director 231-88-6663 1 □ M 2 🕅 F March 15 1956 VA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Director SPRINGDALE MD 1X Yes 2 ☐ No PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 3414 EDWARDS STREET USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 X Never Married 2 A Married ģ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE MAKEUP ARTIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RUTH N. GARDNER TERMON L. MINOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELYN R. MINOR/ SISTER 6813 LAKE CAROLINE DRIVE, CHESTERFIELD, VA 23832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/11/2012 4 ☐ Donation 5 ☐ Other (Specify) BETHANEY CHURCH CEME. MONTPELLIER, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME INC. Waphney 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ Intracere Medical resulting in death) Examiner Stroke emic Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit ubwachn or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 1 Notermying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SEPTEMBER 5 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORLEANS ST BALTIMORE MD 21287 Ricke Messer 1800

State Registrar 31. Date filed (Month, Day, Year) SEP 1 2012

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SOURCE  SOURCE	Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contribute to the significant conditio	ry Day Year
24a. Was an autopsy performed? 1   Yes 2   X No    1   Inpatient 2   ER/Outpatient 3   DOA    Other: 4   Nursing Home 5   Residence 6   X Other (Specify 27)   No    Specify 28b. Time of 28c. Injury at 28d. Describe how injury occurred	e cause of death?
25. Was case referred to medical examiner?  1	sy findings available apletion of cause of
27. Manner of Death  28a. Date of injury at 28d. Describe how injury occurred	HOSDICE
The state of the s	HOST TOE
27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 1 Yes 2 No 28b. Time of injury at work? 1 Yes 2 No 28b. Time of injury at work? 1 Yes 2 No 28b. Time of injury at work? 28c. Injury at work? 28b. Time of injury at work? 28c. Injury at work? 28b. Time of injury at work? 28c. Injury at work? 28c. Injury at work? 28d. Describe how injury occurred	Route Number,
The state of the s	se(s) and manner stated ated.
1 ml + galacscart R149792 9/10/20	2
30. Name and address of Selson who completed cause of death (Item 23a) (Type, Print)  JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093  State  31. Date filed (Month, Day, Year) 2012  32. Registrar's Signiture	

amend #5, per fh, g931 9-14-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25, PER ME D931 9/5/12 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Auq. Jack Daniel Morningstar 22<sup>Day</sup> 201°2 3:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 2219=18-9737 Director 1 M 2 D F 87 4/16/1925 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Carroll 1 Yes 2 No New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 Marston Road 21776 USA filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 S Yes 2 No 1940 ≈
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced 1949 Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Refrigeration permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Leroboth Carrie Morningstar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Morningstar-wife 2500 Marston Rd., New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 8/23/12 Winfield 21. Signature Fun ral Service Licensee 22. Name and Address of FacilityFletcher Funeral Home, P.A. 254 Ε. Main St., Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICAT Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day a | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2ٍ| 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Tes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying | The Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 0 Name a (Item 23a) (Type, Print) WESTMINSTER 32. Ber State strar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup> 20<u>12</u> Month Mary A. MacLeary Sept. Medical 6:35 p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6 Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) **Director** 212-32-7666 1 □ M 2 13 F 76 May 9 1936 MD ir than "natural", or Items 23a or 28e-f show the Medeal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2 🙀 No MD Baltimore <u>Cockeysville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9815 Monroe St. 21030 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 1 Married \$ 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 end 2 should be file Department of Health and Mental I Important: If item 27 Is marked o eny Injury or other treumatic eve once. Eugene Sullivan Viola Shoul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David MacLeary/husband 9815 Montoe St., Cockyesville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State /13/12 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Fundal Son 22. Name and Address of Facility Michael Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) eta eta Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): • Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the ettending physicien end etelly filled in by the funeral director, page 2 should be detached for use es the burial-transit ause (Disease of Injur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) ည 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Sp 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certif 29d. Date signed (Month. Day, Year) MD 71040 8 2012 KUMAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHI

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28895 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Patrick Russell Myers, Sr. Sept. 2012 2:14 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2520 Masseth Avenue Baltimore Co. Edgemere Social Security Numbe If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) **Director** 218-36-2532 Dec. 25,1940 Usual Residence of Decedent Maryland items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2520 Masseth Avenue 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 □ No If Yes, Give Year or Dates**Korean**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ortant: If item 27 is marked other than "natural", or itei injury or other traumatic event, the Medical Examiner. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Maintenance General Motors Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Myers Thelma Tegeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Ann Myers (Wife) 2520 Masseth Avenue Edgemere, Maryland 21219 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Oak Lawn Cemetery 9/12/2012 4 Donation 5 Other (Specify) Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Metastatic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pendina 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of pe ho completed cause of death (Item 23a) (Type, Print) West Redwood. John Long 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 5 2. Date of Death **Physician** Month 6:46PM SEPTEMRER 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES 10SPITAL ALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 💢 F 8 566 36 1901 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinational by puting at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland 10e. Street and Number Himore WENCH 10g. Citizen of What Country? 10f. Zip Code A HR627 by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 3 ₩ Widowed 4 □ Divorced M Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event security." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1ammer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Comments of the place)

Comments of the place of t on 3126 Birch Brook Lane, abingdon 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ R

4 ☐ Donation 5 ☐ Other (Specify) Date Location - City or Town, State 3 Removal from State 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapit and Creations Funeral Chapit and Cr 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗵 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 1 ☐Yes 2 No After this certific funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier RESIDENT MD P27688

Registrar
DHMH 17 Rev 1/2001

10

State

31. Date filed (Month, Day,

9005

egistrar's Signature

CATON AVE, BALTIMORE, MD-21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Marylar		artment of		and M	1ental Hy	giene 2	012	28	897	
	_		Registrar  1. Decedent's Name	(Eirst Middle	l act)		Cer	tificate of	Death			Reg. No.	012			
	Physicia Medic		MA	RY	MAT	TIN					2. Date of Dea	Day Day 7	2012	3. Time of	P M	
-	Examin	er	4a. Facility Name (if )		give street and nu MaRiS	mber)		4b. City, Town,				4c. Cou	nty of Death	ore Co		
	Funeral Director		5. Social Security Nu		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birti (Month, Day		9. Birthp	place (State or try)	Foreign	
			579–26–3 Usual Residence o	f Decedent	1 □ M 2 <b>½</b> F	85	Yrs.				Oct. 11	<b>,</b> 1926	Washi	ington,	DC	
	aryłanc ra-f sho ified at	Director	10a. State MD	10b. County  Montge	omery		y, Town or Loc <b>ckvill</b> e						1	0d. Inside Cit		
	a or 28		10e. Street and Num					10f. Zip Code			T	10g. Citizen o		itry?		
	ath witl	Funeral	12921 La	rkin P		edent Ever in U.	S 13 V	Vas Decedent of I	20853	igin? (Sne	cify Ves or No-	US				
9800	e flied within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 <b>X</b> Never Marrie 3  Widowed 4		Armed F	orces? 2X No ve	i ii	Yes, specify Cub	an, Mexica	n, Puerto	Rican, etc.)	В	ace - Americ lack, White, e ify: Whit	etc.		
15-(	72 hou n "natu Aedica	Completed		cify only highes	t's Education at grade completed		(Give F	ent's Usual Occu iind of work done O NOT use retired	during mos	at of worki	16b. Kind of Business/Industry					
212	Hygiene.  other thar ent, the M		Elementary/Second 12	ndary (0-12)	College (	1-4 or 5+)	Moth		,			Professional				
Maryland 21215-0036	should be filed h and Mental Hy 7 is marked oth raumatic event	To Be	17. Father's Name (F William		ast)						(First, Middle, I Link	Maiden Surna	me)			
, Mar	permit. Page 1 and 2 should be fit Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Nar Pam Fras					g Address (Street				-		Code)		
Baltimore,	age 1 an ent of He nt: If iten y or oth			XCremation	3 Removal from	n State	emetery, crem	sition (Name of natory or other pla			)ate		n - City or To			
3altir	ermit. Pa epartme nportan ny injuri nce.		4 ☐ Donation  21. Signature of Fin					rney Cre					oine, N			
		21. Signature of Exheral Service Licensee  M01651  M01651  22. Name and Address of Facility Coing Home Cremation Service P.O. I Beverly L. Heckrotte, P.A. Clarksv.  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											sville	Approximate		
- 1	tignician/		shock, or heart Immediate Cause (F disease or condition resulting in death)	inal	a	Carric		MAY	awe	51				Interval Betw Onset and D	reen	
	Medical Examiner			1	Due to	C WSTE		Difficule	>							
	ed sit	dical Examiner	Sequentially list con if any, leading to im- cause. Enter Underl Cause (Disease or in	mediate ying	Due to	(or as a consequence of the cons		,								
	executa an and rial-trar	Еха	that initiated events resulting in death) L		c. Due to	(or as a consequ										
09/	cate be executed physician and s the burial-transit	edica		8	d	ASDIZ	MITA									
Box 687	ocertific ending	an/Me	IF FEMALE: 23b. Was decedent p			itcome of pregna		Ectopic pregnan	CV			23d. I	Date of delive	ery		
). Bo	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 m 1 ☐ Yes 2 🛣 9 ☐ Unknown			gnant at time of o		Other (specify)					Month	Day Ye	ear	
ls, P.O.	uires that n signed uld be de	اج	Part II. Other signific	,	s contributing to a		ulting in the ur	nderlying cause g	ven in Part	l.		_		e cause of de ably 4 CU		
COLC	law req las bee e 2 sho	Completed	HIO TI	A							24a. Was a	Sy	prior to cor	sy findings av	ailable use of	
E Be	n: The ificate I		25. Was case referred					00.5	l	Al- (011-	perfor	med? 2 No	death? 1 Yes	2 No		
Vita	nysicia nis cert I direct	To Be	examiner? 1  Yes 2	_	Hospital:	Inpatient 2	ER/Outpatien	Oth	lace of Dea ler: 4 TN		ne 5 🗆 Reside	ence 6 🗆 O	ther (Specify)			
n of	ding Pt h. After th funera	ate:	27. Manner of Death	5 Pending	4	of injury oth, Day, Year)	28b. Time of injury	28c. Injui wor M 1	y at	2	8d. Describe ho					
Division of Vital Records,	or Atten ifter deat Sirector: in by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investig 6 Could n determin	ot be 28e. Place	e of Injury - At ho ing, etc. (Specify	me, farm, stre		Tes Z	-	28f. Location (St City or Town		ber or Rural	Route Numbe	ır,	
۵	bours a uneral Diffiled	Medical (	29a. Certifier 1	Certifying	Physician: To the I	pest of my knowl	edge, death o	ccurred at the tim	e, date and	place, an	d due to the car	use(s) and ma	nner as state	d.		
	the Ho thin 24 the Fu		(Check 2 only one) 3 29b. Signature and ti	Certifying	aminer: On the ba	sis of examination. To the best of n	n and/or investi ny knowledge,	death occurred at	the time, da	ccurred at te and pla	ce, and due to th	e cause(s) and	manner as s	tated.	ner stated.	
	¥ ≥ ¥ 8		Dob. Giginature and the	MM				29c. Licens	6 number 31971	6		29d. Date sign	120 12 12			
	151		36. Name and addres	/ 11	ho completed cau	se of death (Item			1 Rd	TI	nmium,		21093			
	Stat Registra	_	31. Date filed (Month,			Registrar's Signat		)								
		4		- 2012	LENGTH	/* /*	F 97 47									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28898 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ MCINTARE September 9. 20PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEDSTAR HARBOR HOSPITAL BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth **Director** 214-04-6396 1 □ M 2 🕱 F 44 01/29/1968 Maryland Usual Residence of Decedent 28a-f show 10a. State Director 10c. City, Town or Location notified 1 Yes 2 K No Anne Arundel Glen Burnie 10e. Street and Number ō 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral [ 301 W. Furnace Branch Road 21061 U.S.A. should be filed within 72 hours after death "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Veterinary Technician Veterinarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked of မှ of Health and Menta of Health and Menta firem 27 is marked rother traumatic e Robert Lewis Beard Cynthia Frances Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Bristol Court, Crownsville, MD 21032 Cynthia Beard / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 tof . If i cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once, 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 109/07/2012 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr. Ste. P, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Varian disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death been signed by the a should be detached 1 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Frospires.
124 hours after death.
e Funeral Director: After this certificate has b. 24a. Was an autopsy performed? 2 🗌 No Yes 2 N completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) Signature and title of certifie 00072328

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CMVA

RAGNURAM

MEDSTAR HARBOR KOSPITAL BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28899 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Comber 4 Physician/ 55 aMedical 4a. Facility Name (if Not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Months Hours Director 219-08-9511 1 M 2 X F Yrs. 42 08/26/1970 California 28a-f show in than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 22 South Duncan Street U.S.A. 21231 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Food Preparer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvey Pate Spiker Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr once. East Macphail Road, Bel Air, MD 21014 Amanda Nolan / Daughter 403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) 09/07/2012 Anatomy Gifts Registry |Hanover, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 No 9 Munknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 TYes 2. No Other: မ Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eviner -1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death September Physician/ 201<sup>Y</sup>2<sup>ar</sup> 1:00 A M Mark J. Morein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 166-42-7341 Director 1 **X**] M 2 □ F 62 August 8, 1950 Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No N. Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or Funeral 20878 United States 12701 Young Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Kay Zolitor Albert Morein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 12701 Young Lane, N. Potomac, Maryland 20878 Marilyn Morein/Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of September 10, 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium Bethesda, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licens Bethesda-Chevy Chase, Inc. Maryland 20814 Rôbert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, William M01173 Tump Mess Approximate Interval Betweer 23a. Part 1. Enter the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and if for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 5 Other (specify) Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has death? After this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5:00 M work? 1 ☐ Yes 2 🔀 No Natural 5 Pending Fell down 12 steps X Accident
Suicide 9-1-2012 To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number City or Town, State) 12701 Young Lane N. Potomac, Maryland 4 Homicide determined at home 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D71462 September 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland Dan Danila, M.D. 31. Date filed (*Month*, *Day*, *Year*) **SEP 1 1** 2012 /32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, Physician/ 2012 Barbara Sayre Monroe September 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 525-88-4151 Director 1 M 2 D F 75 March 7, 1937 New Mexico Usual Residence of Decedent r than "netural", or items 23a or 28a-f shov the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "netural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 8300 Burdette Road, #541 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 Never Married 2 X Married þ 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vera Simpson Lauren Sayre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pege 1 end 2 shament of Health a lant: If Item 27 is 8300 Burdette Road, #541, Bethesda, Maryland 20817 K. Monroe / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State September permit. Pege 1 Department of Important: If It eny Injury or o 1 Burial 2 X Cremation 3 Removal from State 11, 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 21. Signatur of Fur eral Service Liber Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Nars Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physiclen: The law requires that the death certificete be executed ettending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical R Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 Yes 22 9 Unknown the detached 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending ☐ Natural work? 1 ☐ Yes 2 🕅 No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu unt 2 Accident 3 Suicide 4 Homicide Sup 3 20/2 Investigation 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route(Number, City or Town, State) 63 0 0 0 0 0 1 1 1 Home m 0 practe 2051 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 8600 Old Georgetown Anitha Chetty, M.D Road, Bethesda, Maryland 20814 State 32. Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Hospice of Chesapeake Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 219-10-9481 Hours (Month, Day, Year) Country) Director 1 🔀 M 2 🗍 F 86 8/3/1926 Marvland 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1730 Pleasantville Dr., Apt. 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 1 Married 1 X Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White 3 Divorced Year or Dates.44-46 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Welder Government Be 17. Father's Name (First, Middle, Last)
William Miller 18. Mother's Name (First, Middle, Maiden Surname) Helen Beares ౖ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Miller 1730 Pleasantville Dr., Apt 2B, Glen Burnie, MD 21061 injury or other Baltimore, Jepartment of He Importent: If Item eny injury 20b. Place of Disposition (Name of cernetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet Cem 9/12/2012 Crownsville, MD 22. Name and Address of Facility Ambrose Funeral Home 21. Signature of Finneral Service Licer 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PVI OXVII Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Due to (or as a consequence of): Exami The law requires that the death certificete be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death as been signed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page death? 2 No Yes 1 Tyes or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 8 examiner? Hospital Other: 2 No 1 🗌 Yes House ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cartifier 29c. License number 21438 ma 067012 Name and address of person who completed cause of death (Item 23a) (Type, Print) W 8 31. Date filed (Month, Day, Year) 32. Registrar's Signatury State Registrar

MDHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mode Physician/ September Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death 00 Baltimore If Under 1 Year | If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min 6/23/1925 New York Director 129-14-3808 1 **X** M 2 □ F 87 shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is markad other than "natural", or items 23a or 28a-f showeny Injury or other traumatic event, the Mechal Evanding must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Marvland Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Laurelford Court 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Philanthropist Baltimore Ravens Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Modell Kitty Malzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 David O. Modell / Son 307 International Circle Suite 306 Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Druid Ridge 9/11/2012 Pikesville, Maryland 5/X Other (Specify) Entombmen . Signature of Juner 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the dis-ass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Mesenteric Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause or injury Due to (or as a consequence of): Examil ieral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed/ 2 M No 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🖭 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 2 Accident 1 Yes 2 🗆 No Investigation Director: Suicide 6 Could not be within 24 hours after d To the Funeral Direct completely filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signatyre and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 1300 N. Orleans St. Baltimore MD 21287 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begibles State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2012 Michael Bernard McGarity A M 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1238 Ten Oaks Road **Baltimore** Halethorpe Social Security Numbe 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours Min (Month Maryland Director 213-42-4484 68 June Usual Residence of Decedent show at 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? must be Completed by Funeral 23a death with 1238 Ten Oaks Road U.S.A. 21227 ral", or items? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) item 27 is marked other than other traumother traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Ship Work Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Edward F. McGarity Margaret Loudenslager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Halethorpe, Maryland 21227 Christy McGarity (wife) 1238 Ten Oaks Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9/10/2012 Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Fun 1 21. Signature of Funeral Service Licensee Msk Home of Catonsville, INC. 1630 Edmondson Ave. M01050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Jeens Di Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or acryling Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharton

falls

(2)7 Registrar's Signa 29c. License number

133709

29d. Date signed (Month. Day, Year)

9/10/12

Rd #415, Latreville, M. 21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death tagust **Physician** 10:29 Faith Aria Norris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 13 INFANT Aug 16, 2012 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Carroll Mt. Airy 1 ☐ Yes 2 🖾 No 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 6108 Ridgeline Dr. 21771 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite Black, White, etc 6 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White 2 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) Item 27 Is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) INFANT College (1-4 or 5+) INFANT INFANT INFANT 17. Father's Name (First, Middle, Last) 11nk 18. Mother's Name (First, Middle, Maiden Surname) Be Dana Bernardo ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Bernardo - mother 6108 Ridgeline Dr; Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State 4□ Donation 5 Rother (Specify) in state 21. Signature of Foreral Service Vicensee Ronald S. Wa 22. Name and Address of Facility State Anatomy Board 6 655 W. Baltimore St; Baltimore, MD Part 1. Firster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Onset and Death Physician . Pneumomediastinum disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tracheal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Extreme Prematur the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) n signed by the at uld be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 epidermidis Staphy lococcus 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? cardiagenic SNOCK certificate 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 5 Pending investigation Natural (Month, Day within 24 hours after death. To the Funeral Director; After completely filled in by the fur 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

Division of Vital Records, P.O. Box 68760 or Attending Hospital

3

(Bernardo

Norrig

Laitz

State Registrar

Medical

31. Date filed (Month, Day, Year)

Janice

SEP 1 1 2012

29b. Signature and title of centifier

29a. Certifier

(check only one)

30. Name and ad

Hobbs MD 32. Registrar's Signature

RES-000 ess of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) August 29,2012

4940 Eastern Avenue, Baltimore, MD, 21224

MD

Physician X /Medical Examiner 0 Bernard **Funeral Director** with the Maryland or 28a-f show ò ral", or items 23a o Examiner must be Norvi filed within 72 hours after the Medical Baltimore, Maryland 2121 other than permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 Is marked other tangen any Injury or other traumatic event, thusones. 0 **Physician** /Medical

1. Decedent's Name (First, Middle, Last)

Hope Skyler Norris

**Examiner** 

or Attending Physician: The law requires that the death certificate be executed burial-tran and as the l attending plant ed by the at detached t pe 2 should has page certificate

this

death.

e Hospital or Attend 124 hours after death e Funeral Director; A

within 2 To the the

in by the funeral

completely filled

of Vital Records, P.O.

Division

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 16, 2012 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 🗆 M 2 🔯 F INFANT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director Carroll MD Mt. Airy 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21771 6108 Ridgeline Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) INFANT INFANT INFANT INFANT 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be Dana Bernardo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6108 Ridgeline Dr; Mt. Airy, MD 21771 19a. Informant's Name/Relationship (Type. Print) Dana Bernardo - mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Pther (Specify) in state 21. Signature of Funeral Service Licenses Ade State Anatomy Board 22. Name and Address of Facility Director 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. 655 W. Baltimore St; Baltimore, MD 21201 Immediate ause (Final disease or condition resulting in death) Necrotizing Due to (or as a consequent of): Prema xtreme Secure trally list on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ nflammator Response 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Shor ardiogenic 1 🗌 Yes 2 No 25. Was case referred t → edical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one. Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Detifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice HOBBS MD 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death Month

tugust

28906

3. Time of Death

09:15 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Onset and Death

Year

Day

2 🗌 No

29,2012

1 🗌 Yes

1 ☐ Yes 2 No

Maryland

2012

DHMH 17 Rev 1/2001 11595

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6 Day 2012<sup>ar</sup> Physician/ Sept. 9:45 AM Napierski Barbara Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gwynn Oak 1502 Ingleside Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Oct. 11, 1921 1 🗆 M 2 🔀 F Months Days Hours Min. Maryland Yrs 90 **Director** 216-18-7563 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Tes 2 X No Gwynn Oak Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21228 1502 Ingleside Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give ğ Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) C & P Telephone Co. Telephone Operator 12 permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Applonia Rauch Upman Alphonse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11840 Triadelphia Rd., Ellicott City, MD 21042 Gemma M. Shryock- daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Pk. 9/11/2012 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Survice Licensee M0123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe anema Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami ending physician and use as the burial-transit Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months. 1 ☐ Yes 2 ☑ No g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 15 n lation Gastrointestind bleeding 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s performed? Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending 1 Yes 2 No s after death. Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined within 24 hours at

To the Funeral D

completed filled it Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signatu

Registrar

DHMH 17 Rev 7/2009

State

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of person who completed cause of death (Item 23a) (Type, Print)

			AMI	END 28A-F, PER ME	<b>e Type or Pr</b> G931 9/5/1 State of N	int in Bla 2 TRT laryland	ack In Amend Depa	<b>delible l</b> i 1 28d rtment of	n <b>k. Ens</b> per me Health	ure All Col g 931 97 and Mental	<b>pies A</b> 10/12 Hygier	re Legil TT ne	ble.
				State Registrar				ificate of				No. 20	12 28901
	- Alexandria	Physici Medi		1. Decedent's Name (First, Middle, L Patrick Donald	O'Connor					2. Date of August		Day 14 2	3. Time of Death
•	9	Exami		4a. Facility Name (if not institution, gi	HUSPIT	TAL		BAL.	TIMO	RE		4c. County o	f Death
		Funeral Director		219-80-7627	Sex 7. Ag 1	ge (In yrs. last b 47		If Under 1 Yea Months Days		Min. (Mont	h, Day, Year	r)	Birthplace (State or Foreign Country)
	-	and show d at	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City, To				Aug.	19,	1964	Maryland  10d. Inside City Limits
		ne Mary or 28a-f notified	Direc	Maryland Howard	1		E1kri	dge 10f. Zip Code					1 ☐ Yes 2X No
		th with the ms 23a omust be	Funeral Director	6025 North Meyer	Drive			21075				Citizen of Wh	ISA
	9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minjory or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.	Ever in U.S.		as Decedent of res, specify Cul		gin? (Specify Yes or I, Puerto Rican, etc.	No-		American Indian, White, etc. White
	215-	in 72 ho e. ian "nat Medic	Completed	15. Decedent's (Specify only highest ( Elementary/Secondary (0-12)			(Give kii	nt's Usual Occu nd of work done NOT use retired	during most	of working	16b.	. Kind of Busi	iness/Industry
0!	d 21	Hygien Hygien other then	Be Co	17. Father's Name (First, Middle, Last		91)	Servi	ce Tech		1 er's Name (First, Mic			Supply
M	ylan	uld be fil I Mental narked natic ev	은	William R. O'Cor	nor				Lo	retta M.	Borc	hardt	
To	Baltimore, Maryland 21215-0036	and 2 should   Health and Me Health and Me Her tranmati		19a. Informant's Name/Relationship A. Jennier O'Co	Onnor – Wif	:e (	6025	North M	eyer D	r or Rural Route Nu Prive, Ell	mber, City cridg	or Town, Stat e, Mar	te, Zip Code) yland 21075
ax ax	imore	Page 1 ament of Hant of Hant: If ite		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cemet	terv. crema	ion (Name of tory or other pla remator	y In¢.	Date 08/18/12			ity or Town, State rnie, Maryland
K	Balt	permit, Departi Import any inj		21. Signature o Funeral Service/Lice	Brokan	w Z	22. 1	Name and Addr	ess of Facility	Gary L.	Kaufi	man F.	
				23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused one cause on each line	e. • 1	not enter	he mode of dy	ing, such as o				Approximate Interval Between
(	and a	Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as	Winor a consequence	e of):	embo	hsm	<del>/</del>			Onset and Death
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	092	cate be ey physician the buris			d	· 			CERTIFIC	TION APPROVED BY			
	. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  For hours after death, after this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal dea		ctopic pregnar Other (specify)	licy V	/	_	23d. Date o	*
CK	, P.O	es that the signed by be deta	ह्य	Part II. Other significant conditions	contributing to death b	ut not resulting	in the unc	erlying cause g	iven in Part I.	-55.2			ute to the cause of death?
ATRIC	Records,	w requir s been s 2 should	Completed								∐ Yes : Vas an	24b. Wer	Probably 4 Unknown re autopsy findings available
PA	Rec	sician: The law certificate has irector, page 2 s								p	utopsy erformed? es 2	dea	or to completion of cause of the other than the oth
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02	ot	ing Ph Vfter thi funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of injui (Month, Day	ry 28b.	Time of injury	28c. Inju	ry at k?	28d. Descri		iry occurred	specify)
JONNOR,	Division of Vital	or Attending Phaffer death.  Director: Affer thi I in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not determined	28e. Place of Inju	ry - At home, fa	lO PM arm, street		Yes 2X	28f. Location	n (Street a	nd Number o	or Rural Route Number,
	Ω	spital or A ours after eral Direc filled in by			GARAGE A	AT FRIE				City or	Town, State	%025 ന	DUCKEYS RUN
0		To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	only one) 3 Certifying Nu	vsician: To the best of a niner: On the basis of ex- se Practitioner: To the	(amination and/	or investiga	tion, in my opini	on death occ	curred at the time do	to and place	a and due to	the equec(e) and manner etated
4		or wit		29b. Signature and tyle of certifier	-mo			29c. Licens	number 3 7 3 5 3		29d. D.	ate signed (M	Nonth, Day, Year)
				30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Prin	venue	Br	Utmore	MA	12/11-	1 21229
	i	Stat Registra	~	31. Date filed (Month, Day, Year) SEP 11	2012 32. Registra	r's Signature	1. 6	arke	1 - 0			1100	14, 2012 14, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2004

Pilysician Medical Examiner  Facility Name (Final, Medical, Lass)  Felicia Olmo  Some of the institution of the state of Death Month Property Olimeter  Function  Fig. 1 Deaceder's Name (Final, Medical, Lass)  Felicia Olmo  Some of the institution of the state of Death Month Property Olimeter  Fig. 2 Death of Death Month Property Olimeter  Fig. 3 Time of Death Month Property Olimeter  Fig. 4 City, Town, or Location of Death Anne Arundel  So. City, Town, or Location of Death Odenton  Fig. 4 City, Town or Location Month Property Olimeter  Fig. 4 City, Town or Location Month Property Olimeter  Fig. 4 City, Town or Location Month Property Olimeter  Fig. 5 City, Town or Location Month Fig. 6 City, Town or Location Month Fig. 6 City, Town or Location Month Fig. 7 Age for yes, sate study only or Location Month Fig. 7 Age for yes, sa	1		1 - State of Maryland / Department of Registrar Certificate of		giene 2012 2890 Reg. No.
## Facility Name of not institution, give street and number! ## Baart Homes at Piney Orchard Piney Orchard ## Baart Homes at Piney Orchard Piney	hysician/		cian/ Falicia Olmo		eath 3. Time of Death
Social Security Number   OB9 = 26 - 8008   Sex	Examiner 48	a Ving	niner 4a. Facility Name (if not institution, give street and number) 4b. City, Town,	or Location of Death	4c. County of Death
The state of the s	uneral 5. rector (		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	r If Under 24 Hrs. 8. Date of Bir B Hours Min. (Month, De	th g. Birthplace (State or Foreign Country)
Ph. sici.n Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate oause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Ba-f show tiflied at rector	Maryland Ba-f show tified at	Usual Residence of Decedent  10a. State  10b. County  MD  Anne Arundel  Odenton	37207	10d. Inside City Limits 1 □ Yes 2  No
Ph. sici.n Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate oause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	is 23a or 2 nust be no neral Di	is 23a or 2 nust be no nust be no	10e. Street and Number 8735 Piney Orchard Parkway 211	113	10g. Citizen of What Country?
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,    Approximate Interval Between Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)    Sequentially list conditions, if any, leading to immediate oduse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):	the Medical Comple	21215- within 72 ho giene. er than "nai , the Medici	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Administrat	during most of working	
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Physician Medical Examiner  Sequentially list conditions, if any, leading to immediate ocuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		Depart De			
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To be a completion of cause of death?  24a. Was an autopsy performed?  1 Yes 2 I No 3 Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 I No 3 Probably 4 Unknow  24c. Was an autopsy performed?  1 Yes 2 I No 2 Yes	r, page 2 shou	I Record I: The law required has been and the page 2 should be complete.		24a. Was a	an 24b. Were autopsy findings available prior to completion of cause of
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   1   O 3   Probably 4   Unknow  24a. Was an autopsy performed?  1   Yes 2   No 3   Probably 4   Unknow  24a. Was an autopsy performed?  1   Yes 2   No 3   Probably 4   Unknow  24a. Was an autopsy performed?  1   Yes 2   No 3   Probably 4   Unknow  24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No 3   Probably 4   Unknow  24c. Place of Death (Check only one)  25c. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Unknow  25c. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Unknow  25c. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Unknow  25c. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Unknow  25c. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Unknow  26c. Place of Death (Check only one)  26c. Death (Check only one)  26c. Place of Death (Check only one)  26c. Place of Death (Check only one)  26c. D	the funeral directoring the fu	ion of Vital tending Physician leath. for: After this certificer the funeral direct	examiner? 1   Yes 2   Do   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Oth	er: 4 Nursing Home 5 Resid y at 28d. Describe h	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Location (Street and Number or Rural Route Number, City or Town, State)	filled in by	Divis pital or At ours after o eral Direc filled in by		City or Tow	n, State)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Media Media	To the Hos within 24 h. To the Fun completely	OCI Ci natura de Livido Carrier	on, death occurred at the time, date ar the time, date and place, and due to the	nd place, and due to the cause(s) and manner stated. ne cause(s) and manner as stated.
Suedd Many D20094 09/05/12  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			Elledy May Das	9094	09/05/12
State 31. Date filed (Month, Day, Year) 32 Afgeistrar's Signature	01	State	Elliott Gorberty up, 1411 Madison Va	ink Prive ble	Burpil, Md, 21061
Registrar SEP 1 1 2012 Annual S. Aparla DHMH 17 Rev 06-2011	egistrar	Registrar	trar SEP 1 1 2012 Cenus A. Janes		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Marylar		artment <i>rtificate</i>				Mental Hy	giene Reg. No.	7111/	28910
	Physic /Medi		1. Decedent's Name (First, Myrtle		rcy							2. Date of De Month		/ Year	3. Time of Death
4	Exami		4a. Facility Name (If not inst	itution, give st	reet and numi	ber)		4b. City, To	own, or	Location	of Death		4c.	County of Death	
	1		FRANKLIN S	SQUARE	MEDIC	AL CE	VTER			DAL				BALTIMO	RE
	Funeral Director		5. Social Security Number 216-40-215		M 2 🕌 7		. <i>last birthd</i> ay) 9 Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Sept.	27,1	9. Birthp	lace (State or Foreign try) MD
	and		Usual Residence of Deceder 10a. State 10b. Co			10c. Ci	ity, Town or Lo	ocation						1/	Od. Inside City Limits
	he Mary 28a-f sh	ector		ltimo	re			Mi		e R	iver				1 □Yes 2 No
	ath with the Marylan s 23a or 28a-f show	ral Dir	10e. Street and Number 705 Compa	ss Ro	ad			10f. Zip (	212	220				zen of What Count	try?
9000	72 hours after death with the Maryland 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dion! Evarriner must be motified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 🌁 Widowed 4 □ Divo	Married	Mas Decede Armed Force 1 ∐Yes 2 If Yes, Give Year or Date	es? No		Was Decede If Yes, specif 1 □ Yes 2[	3.7	spanic Or n, Mexicar Specify:		ecify Yes or No Rican, etc.)	)-	14. Race - America Black, White, e Specify: Wh	
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7	iled w Hygiel		8th 17. Father's Name (First, Mic	della last)			Но	memak						own hon	ne 
Maryland	should be find Mental Parameter of marked of umatic even	To Be	Jacob H	. ,								yn Lo		Surname)	
	1 and 2 shu Health and em 27 is m wher traum		19a. Informant's Name/Rela Joseph Pi				19b. Mailir 19	ng Address (8	Street ar lir	nd Numbe				Town, State, Zip	
Raltimore	Pages 1 and the last of He last o		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremat 4 ☐ Donaţion ; 5 ☐ Othe		noval from Sta		Place of Dispo cemetery, crem ayviev	natory or othe	er place.		9/7	)ate /12		cation - City or Tov	·
ACY Balli	permit. Departm Importa any inju		21. Signature of Funeral Se		1-3	3110		. Name and	Address	of Facilit	y 30	0 Mace	Ave	e. Balt f Essex	O - MD
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68760	cate be executed physician and the burial-transit	dical Ex	resulting in death) cast	d	Due to (or	as a consequ	uence of):								
99		Med	IF FEMALE:												
O. Box	the ded	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c.	. If yes, outcor 1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow	h 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pred Other <i>(spe</i> c					2	3d. Date of deliver Month [	y Day Year
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<u> </u>	ysicia s cer direct	Δ.	examiner? 1 ☐ Yes 2 🜠 No		pital:	ationt 2 🗀	ER/Outpatient	3 🗆 🗀	Other:			(Check only o			
0	rding Physician: th. : After this certific i funeral director,	Li i	27. Manner of Death		28a. Date of I		28b. Time of Injury		. Injury a Work?			8d. Describe h		Other (Specify)	
<u>.</u>	Attendir death. ctor: At y the fu	atic	2 Accident inv	estigation	(Wierini,	Day, reary	mjary	М		s 2 🗆 N	10				
Divis	al or Att	Certification: To		uld not be ermined	28e. Place of building,	Injury - At ho etc. <i>(Sp</i> ec <i>it</i> )	ome, farm, stre	et, factory, of	ffice		2	8f. Location (8 City or Tox	Street and In, State)	Number or Rural	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certi (Check only 2 ☐ Medione)	ifying Physici cal Examiner	an: To the be On the basis and manner	s or examina	wledge, death tion and/or inv	occurred at estigation, in	the time	, date an	d place, a	and due to the ed at the time,	cause(s)	and manner as sta place, and due to t	ated. the cause(s)
	To the Comp	M	29b. Signature and title of cer	tifier 50 M	CTNAI	Son	۸			number (	MO)		29d. Date	signed (Month, D	ay, Year)
0	0./		30. Name and address of pers	eon who some	loted entres -	f dooth (14-	.00a) /T		46	44				9/6/12	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:50 September Day p. 20**1**2 Virginia Ann Parker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 907 North Hill Road Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days 1 □ M 2 🛣 F 5(M30th 1930)ear Yrs MD 2**19-30-3**895 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore 1 👽 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 North Hill Road USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: African-American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Foodservice</u> Johns Hookins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Tyler Sarah Tvler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Ann Scott/Daughter 60 Trout Brook Circle, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Cother (Specify) King Memorial Park 9-14-2012 Woodlawn, MD . Signature 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Funeral Surviced ideases 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death YPERTENSIVE disease or condition resulting in death) CARDIOVASCULAR Du to (or as a consequence of):

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760 ne attending phy

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à	lled in by the funeral director, page 2 should be detache		al Certificate. To Be Completed by Dhys
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**Funeral** 

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Department of Health ar Important: If item 27 is any injury or other trau

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Baltimore, Maryland 21215-0036

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псате:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No		e how injury			
I Cert	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factor)	ory, office		n (Street and Town, State)	Number or Ru	ıral Route	Number,
Medic	Check 2 L Medical Examin	ician: To the best of my knowl ner: On the basis of examination e Practioner: To the best of my	n and/or investigation. i	n my opinion, death occurred	at the time da	te and place	and due to the	callegie) ar	nd manner state
	29b. Signature and title of certifier			9c. License number			e signed (Mont		ar)

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09-10-2012

REISTERSTOWN

Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BUSINESS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28912 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vivian Elaine Patterson 0 Honth 28<sup>Pay</sup> 2012 7:45p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death 827 N. Arlington Apt 108 Baltimore 090-40-1592 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 1 M 2 X 64 04/23/1948 New York item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 827 N. Arlington Apt 108 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirance. 1 ☐ Yes 2 🔀 No If Yes, Give Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 Elementary/Secondary (0-12) College (1-4 or 5+) Mental Health Aid Catholic Charities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reuben Fears Sr. Esther E. Williams 19a. Informant's Name/Relationship (Type, PriDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 B. Allenhurst Rd., Buffalo, NY 14226 Yolanda A. Patterson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lombardo F/ H 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 09/04/12 Buffalo, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 子分野色的計が計55 BFで数 Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physiciani 01 disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the effection and the continuation of the continuation attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death 9 Unknown Month signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by eral Director: After this certificate has been si filled in by the funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier hysician: To the completely (Check Medical xaminer: On the basis of exa 3 Certifying Nurse Practif within 2 only one oner: To the st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co cause of death (Item 23a) (Type, Print) Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Louise Palmer Month 201 Medical Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death osedale allare **Funeral** 8. Date of Birth (Month, Pay, Year) Sept. 4, 1940 Birthplace (State or Foreign Country) 218-34-4092 Director 72 1 □ M 2 💢 F Clearspring, MD "natural", or items 23a or 28a-f show edical Examiner must be notified at County 10c. City. Town or Location Director Baltimore MD Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2720 Glendale Road 21234 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Medical Registered Nurse r and Mental Hygien 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Walter Gano and 2 should be the Health and Menta Mabel Helena Kensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2720 Glendale Road Parkville, Maryland 21234 27 Aubrey Palmer- Husband Department of Healtl Important: If item 2' any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September Date 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 11. 2012 of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Farkville, MD 21 2 3 4 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph si∟ian deease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Pulmonary Disease .0bs+ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: elaw requires that the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 C Physician/Medical IF FEMALE: asn. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant : 9 Unknown 9 Unknown een signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work 1 Tes Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) een ivasan 9000 Franklin Square Dr. Balto, MD 21237 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death dent's Name (First Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 2406 Banger Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 1 X M 2 □ F 219-86-8078 09/30/1964 Maryland ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2406 Banger Street 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ğ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21☑ No ene. r than "natural", Specify. 3 Widowed 4 Divorced Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Primportant; if item 27 is many injury or other and Mental Hygien Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Peters Dolores Zaciaczunski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Williams Peters / Common Law Wife 2406 Banger Street, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/6/2012 Chesapeake Crematory Beltsville, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services. PO Box 1413 Baltimore. MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final )ISEASE Physician STAGE こんり disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physiclan and ; page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably LUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has perform 2/2 2 1 No 1 Tes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) [교 1 Yes 2/1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ₩ Natural М 1 Tes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 285 uele 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar ASNEEM

31. Date filed (Month

Registrar's Sign

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WINGS MILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:31 PM loan Medical 4a. Facility Name (if obt institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balti More 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 0377571960 6410 Director TN 28a-f shov er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Ves 2 No Anne Arundel Jessup MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20794 2966 Jessup Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cinemark Human Resources Manager Be permit. Page 1 and 2 should be filed.
Department of Health and Mental P.
Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Phyllis Russell Joe Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2966 Jessup Road, Jessup, MD 20794 Thomas Pattison, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Other (Specify) Grant Memorial Park Marion, IN 9/8/12 21. Sign 22. Name and Address of Facility Harman Funeral Service, PA 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner 10 16 Carcinoma Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Dunito (or as a nonsequence of -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Pregnant at time of death the g Unknown 9 Unknown the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 🛛 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours a Medical

Registrar DHMH 17 Rev 7/2009

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State

within 2

29a. Certifier (Check

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type,

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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П	Physicia Media		1. Decedent's Nam	e (First, Middle, Las -/ /EN	) - F	3007	Poor 2. Date of Death Month 8 Day							3 201	3. Time of Death Z 5, 16 AM
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	Funeral Director		5. Social Security N 220-16-7: Usual Residence	382	ex 7. Ag	e (In yrs. last bir <b>86</b>	thday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da <b>Mar 1</b>			thplace (State or Foreign untry) MD
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, Maryland	and 2 should Health and Me tem 27 is mar ther traumati		19a. Informant's Na <b>Wendy Ku</b>	ame/Relationship (T mar Daughi	vpe, Print) <b>ler</b>	191	. Mailind	g Address (S <b>hurch</b>	Street ar <b>Rd. E</b>	nd Numbe	r or Rura City, i	Route Numbe	er, City or Towi	n, State, Zij	o Code)
Baltimore,	Page 1 and 2 ment of Healt ant: If item 2 ury or other:			oosition Oremation 3  5 Other (Special	Removal from State	20b. Place o cemete <b>Atla</b> i	of Dispos ery, crementic Cr	sition (Name latory or oth rematory	e of ner place <b>', LLC</b>	)		Date 1, 2012			Town, State rnie, MD
Balt	permit. Page 1 Department of Important: If it any injury or o		Sign the of the	neral Service Live	V	2053	22.	Nan <b>Slack</b> 3871	Affune Old C	ral Hol olumbi	ne, P.A a Pike	\. Ellicott Ci	ty, MD 210	43	
	h sician/ Medical Examiner	1	shock, or hea mmediate Cause disease or condition resulting in death)	rt failure. List only o (Final on	1		3 R€				cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
0	be executed sician and burial-transit	cal Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	injury	c	a consequence									
. Box 68760	ss that the death certificate be igned by the attending physic be detached for use as the bi	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal deat		Ectopic pre Other (spec		,				Date of de Month	livery Day Year
ls, P.O.	uires that the signed by ald be deta	þ	Part II. Other signif	ficant conditions o	ontributing to death b	ut not resulting	in the un	nderlying ca	use give	en in Part I					the cause of death?
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/ital	ysician; The is certificate director, pag	Be	25. Was case referr examiner?	_	Hospital:	ent 2 ER/O		2 🗆 🖂	Other	ce of Deat		only one)	<u></u>	241	76.4
on of \	nding Physath. r: After this re funeral d	Certificate: To	27. Manner of Deat  Natural  Accident	,	28a. Date of inju (Month, Day	ry 28b.	Time of injury		c. Injury work?	at	2	28d Describe			iiiy)
Division	al or Attend s after death il Director: / ed in by the	l Certif	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place of Injubuilding, etc	iry - At home, fa c. (Specify)	arm, stre	et, factory, o	office	•		28f. Location ( City or To		mber or Ru	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	Medical (	(Check 2	Medical Exam	sician: To the best of iner: On the basis of e se Practitioner: To the	xamination and/	or investi	gation, in my	y opinior	n, death oc	curred at	the time, date	and place, and	due to the	cause(s) and manner stated.
			29b. Signature and	title of certifier	) MD	eath (Item 23a)		29c. l	License	number 246	)		29d. Date sig	ned (Month	h, Day, Year)
	10×1		30. Name and addr	ess of person who	completed cause of d	eath (Item 23a)	(Type, Pr	rint)	DI	J. (	70/c	mbin	MD	21	045
	Sta Registr		31. Date filed (Mgri		32. (egistra	ar's Signatur	La	wes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edison Highway Social Security Number 7. Age (In yes last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours Country Director 1 □ M 2 XF 3-1926 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Meryland **Funeral Director** Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sac Harrison itaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Health tem 27 4007 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 8 12012 Halethora 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility E. North Baltimores 1101 23a. Part 1. Enter the disease, or considerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition weeks Medical resulting in death) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 V No
9 Unknown Month Day 5 Other (specify) 4 Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 2 🗀 No 2 🖾 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Stertember 386 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 MESHULAM 97 BALTIMARE 21202 PAUL SVITE 804 MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Verna Lee Russell 2012 Sept Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Hours Min. **Director** 215-60-0214 1 □ M 2 🕱 F 60 Nov.14 1951 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 48 Far Corners Loop 21152 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 5:35 a.m. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 3 Registered Nurse Health Care 2012 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vernon Biscoe Elva Mae Wingate permit. Page 1 and 2 should Department of Health and Mt Important: If item 27 is mark any injury or other. 8 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Mallon Russell/husband 48 Far Corners Loop, Sparks, MD 21152 EPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 9/12/12 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Immediate Cause Final Physician/ BREAST CANCER disease or con Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 VERNA RUSSELL use as F FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy jo Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy fter this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 🗶 No 은 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury death. Director: Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npletely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl

120

State

Registrar

ress of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM,

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Year

Day

2 No

HOSPICE

1 Yes

1 Yes 2 No

MD

white

5:35 A M

JACKÍE JONES, 2300 DULANEY VALLEY RD. CRNP 31. Date filed (Month, Day, Year) **SEP 1 1 2012** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0300 September Ryland Judith Rines 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton HOSD: ta Memoria albot If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) Months Days Country Director 218-38-3921 1 🗆 M 2 🛛 F 70 11/24/1941 Maryland is than "netural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Talbot MD Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 U.S.A. 501 Dutchman's Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? pernit. Page 1 and 2 should be filed within 72 hours effer d Department of Heelth end Mental Hyglene. Important: If Item 27 la merked other than "netural", or I eny injury or other traumatic event, the Medical Examina once. Black White etc. <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Proofreading Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Rines Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Thomas / P.O.A. 31597 Bruceville Road, Trappe, MD 21673 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 09/07/2012 Hanover, Maryland 4 IX Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) yeus Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The lew requires that the death certificate be executed ed by the ettending physicien end detached for use es the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ete hes been signed | page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 № No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after deeth. To the Funeral Director: After this certificete hes I completely filled in by the funeral director, page 2 s autopsy performe 1 Yes 2 No Yes Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL Unyre Norte 219 Suth Win high Street 31. Date filed (Month, Cer.) 32. P gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene For State Registrar 28920 G938, 4/30/2013, JH amend #5 PerFH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death september Day Physician/ 00 AM ABLA J. RIZKALLAH Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARFORD UPPER CHESAPEAKE HOSPITAL BEL AIR 8. Date of Birth (Month, Day, '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 🗆 M 2 😿 F **Director** 9-28-1959 **JORDAN** 52 Usual item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No BALTO. ROSEDALE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 **USA** 5418 BALISTAN ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) NATIONS CONTRACTING PRESIDENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NABIH JABAJI LAILA RIZKALLAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is ROSEDALE, MD. 21237 SON 5418 BALISTAN ROAD ESSA S. RIZKALLAH 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-8-2012 TIMONIUM.MD. DULANEY VALLEY 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 6415 BELAIR ROAD BALTO. MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ocal 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an . Were autopsy findings available prior to completion of cause of has death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Hospital: Other: 2 **N**o မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 12 Kal 1 Natural 2 Accident To the Hospital or Attending within 24 hours after com...

To the Funeral Director: After compared to the funeral principle of the funeral compared to the function of the 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number empleted cause of death (Item 23a) (Type, Print) Month, Day, Year, FP 1 1 20 32. Registrar's Signature State Jacker Registrar

		1	AMEND #1,	Please 25, PER	Type or Pri ME G931 9 State of M	nt in 5/12 arviar	Black TRT	k <b>Indel</b> i epartme	ible In	k <b>. Ens</b> t	ure All	Copie	s Are	e Legib	le.	
			State Registrar					Certifica			ATTO TVICE	incar i ty	Reg. No	201	2	28921
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	Funeral Director		5. Social Security No.	9565	XIM OF	e (In yrs. 1 64	last birthd Yr	Month	der 1 Year ns Days	If Under 2 Hours	Min.	Date of Bi (Month, Da	ay, Year)	48	Birthp Count	ace (State or Foreign ry) MD
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	e Mary r 28a-f notifie	Director	MD 10e. Street and Num	NA			Bal	timor								1X Yes 2 □ No
	with th	Funeral	4403 Wh		Ave			l loi.	Zip Code 21	215			10g. Ci	tizen of What U.S.		ry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 XNever Marri 3 Widowed	ied 2   Married	12. Was Decedent Armed Forces?  1 Yes 2 X If Yes, Give Year or Dates.		S.	13. Was Dec If Yes, sp		ispanic Orig in, Mexican, Specify:	in? (Specify , Puerto Rica	Yes or No- an, etc.)		14. Race - A Black, W Specify:	/hite, e	
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	00 = # 0		23a, Part 1, Enter th	te disease or con	nplications that caused	the deat	th Do not	4300	Wab	ash A	lve,			re, M	d, i	21215
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3 A i, P.O.	es that the dea signed by the e		Part II. Other signifi	cant conditions	contributing to death b	ut not res	sulting in t	he underlyin	ig cause giv	ren in Part I.						e cause of death?
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1,0	ng Phys ter this neral d	te: To	27. Manner of Death	1	1 M Inpation 28a. Date of injute (Month, Day)	ry	ER/Outpa 28b. Tim inju		28c. Injury	4 ∐ Nur ≀at				Other (Sp y occurred	ecify)	
Z Sion	ttendin death. tor: Afi / the fu	Certificate:	1 ⊠ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigatio 6 ☐ Could not b	n			М		Yes 2 1						
Hay 2 Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		4  Homicide	determined	building, etc	: (Specify	)					City or Tov	vn, State)	)		Route Number,
	ne Hose n 24 ho ne Fune pletely i	Medical	(Check 2		rsician: To the best of niner: On the basis of ease Practitioner: To the	xamination	n and/or in	vestigation.	in my opinio	n death occ	curred at the	time date a	and place	and due to the	ne caus	e(s) and manner stated
	To the within 2 To the comple		29b. Signature and ti						9c. License	number	000			te signed (Mo		
	(1)		30. Name and addre		completed cause of de	eath (Item	23a) (Typ	pe, Print)	c+ "	Par 1	tim	(1/2)	n	0 >	17	87
	Star Registra		31. Date filed (Month		32. Registra	ar's Signat	ture A.	par	plan !	- Cel	1 ) 0 4 (	we,		1) -	10	0 /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle | Last) 2. Date of Death 2012 September 296, Physician/ Ann L. Rector Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2 Southerly Court #204 Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-14-5286 Director 1 □ M 2 🖈 F 93 Maryland Oct. 22, 1918 r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 U.S.A. 2 Southerly Court #204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐X No If Yes, Give 1 Tes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) t of Haalth and Mantal Hygiane. If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sallie Harcourt Joseph Armiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Fise-daughter 1203 Captains Court, Towson, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park 20c. Location - City or Town, State Date Dapartmant of Important: If it is any Injury or conce. 1 X Burial 2 Cremation 3 Removal from State 9/10/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 1050 York Road 22. Name and Address of Facility Inc. Towson, Md. 21204 Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tic aneury Hodomina 97 y ews Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical usa as tha IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 - Ectopic pregnancy Month 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 8 After this

Examiner Hospital or Attending Physician: The law requires that the death cartificate be exacuted attanding physician Box 68760 certificate has been signed by the atteringtor, page 2 should be detached for Division of Vital Records, P.O.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Page 1 and 2 should be

Certificate: To funeral within 24 hours aftar death.

To the Funeral Director: Af
complately filled in by the fu

25. Was case referred to me examiner?	edical	26. Place of Death (Check only one)									
1 Yes 2 No	Hos	spital: 1  lnpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 Residence 6 Other (Specify)						
2 Accident I	Pending nvestigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred						
	Could not be determined	28e. Place of Injury - At ho	me, farm, street, facto	ory, office	28f. Location (Street and Number or Rural Route Number,						

only one) 3 L Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and	d place, and due to the cause(s) and manner as stated.
(Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	ed at the time, date and place, and due to the cause(s) and manner state
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

26534 30. Name and address of person who compl e of death (Item 23a) (Npe, Print)

colow (MI) #105 31. Date filed (Month, Day, Year) 32. Registra s Sign

State Registrar

Medical

DHMH 17 Rev 06-2011

			For State	State of Ma	aryland		artment of		and M		2.0	112	2002	, J
	Physicia	an/	Registrar  1. Decedent's Name (First, Middle, Last)		hoth Po		illicate or	Dealii	T	2. Date of Death Moth Day 2012 2:12				J
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	Funeral	P	Stella Maris Hospice  5. Social Security Number 6. Sex		e (In yrs. last i	birthday)	If Under 1 Year	Timo		8. Date of Birt	h	Hari	lace (State or Foreig	an
	Director		224-60-4942 1 Usual Residence of Decedent	JM 2 ☐ F	67	Yrs.	Months Days	Hours	Min.	Mort'2/24/1944 Count Virginia				
	ryland I-f show ied at	ctor	10a. State 10b. County	e- u-d	10c. City, To	own or Loc	n or Location Forest Hill						0d. Inside City Limit	
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, Man	ひたける		19a. Informant's Name/Relationship (Typ Tony Rouse / Husband	e, Print)	1		g Address (Street Dellcrest					tate, Zip C	ode)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once,		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ceme	etery, crem	sition (Name of atory or other pla ike Cremato			/2012	20c. Location -	City or To		
Balt	Poolota Marshall Cooks & Acustoff Maryland Cremation Se									ces, PO B	Box 1413Ba	ltimore	, MD 21203	
wa 1	Physician/		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final	cause on each line.	•			ng, such as c	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death	
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09,	cate be executed physician and s the burial-transit													_
Box 687	th certific ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 <b>X</b> No 9  Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3 🗌	Ectopic pregnant	су			23d. Dat	e of delive	ry Day Year	
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/ital	<b>Physician;</b> The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	ospital:	nt 2   ED/	Outpations	LOsh	lace of Death			. <b>V</b>		HOODTOE	
Division of Vital Records,	ending Phy eath. or: After this the funeral of	Certificate: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	y 28b	o. Time of injury	28c. Injur work	y at	28		ence 6 K Othe ow injury occurre		HOSPICE	
Divisi	tal or Attendir rs after death. al Director: Af ed in by the fu		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		farm, stree	et, factory, office		28	Bf. Location (St City or Town	treet and Numbe n, State)	r or Rural I	Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine 3 X Certifying Nurse	r: On the basis of exa	amination and	d/or investig	gation, in my opinio	on, death occ	curred at th	ne time, date an	nd place, and due	to the caus	se(s) and manner sta	ated.
	with con		29b. Signature and title of certifier	1 CAM	1		29c. Licens	e number	192		29d. Date signed	Month, D	ay, Year)	
			/	npleted cause of dea							1// 5/	~		
	Stat		JACKÍE JONES, CRN 31. Date filed (Month, Day, Year)	32 Registrar	's Signature	Y VAL	LEY RD.	TIMO	NIUM,	MD 21	093			
	Registra	ir	SEP 1 1 2012	Levens	J.	19								

DHMH 17 Rev 06-2011

2:12 p.m.

SEPTEMBER 8, 2012

MARY ROUSE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hydiene

imothy Bruce Rut	1- For State Certific	nent of Health and Mental Hygle cate of Death	Reg. No. 2012 2892
Physician Medical Examine	Decedent's Name (First, Middle,Last)		ate of Death onth Day Year  Jgust 30, 2012  3. Time of Death 1325 hrs
and of	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	235 Blackberry Lane  5. Social Security Number 6. Sex 7. Age (In yrs. last b	Queenstown irthday) If Under 1 Year If Under 24Hrs. 8.1	Queen Anne's  Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	216-66-4459 1XM 2_F 53	Mantha Dave Hours Min	an. 25, 1959 Foreign Country) MD
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	FL Monroe Key		1 Yes 2 X No
e Mary or 28a- ied at	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
er death with the Maryland , or items 23s or 28s-f sho Emust be notified at once.	3324 Riviera Drive 11. Marital Status 12. Was Decedent Ever in U.S.	33040  13. Was Decedent of Hispanic Origin? ( Specify	Yes or No- 14. Race - American Indian, Black,
death or item	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Rica	
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5-0036  ed within 72 hours after dygene. other than "natural", the Medical Examiner.	12	Contractor	t, Middle, Maiden Surname)
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	19a. Informant's Name/Relationship (Type, Print )	9b. Mailing Address (Street and Number or Rural	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: Mitem 27 is ma injury or other traumatic or		3324 Riviera Drive; Key	
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altim nit. Pa sartmer portant	4 Donation 5 Other Specify: LOUG 21. Signature of Funeral Service Liconary		
	(Mu He	Funeral Home of Cato 1630 Edmondson Avenu	ling Ashton Schwab Witzke nsville, Inc. e: Catonsville, MD 21228 biratory arrest, shock, or heart   Approximate Interval
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or resp	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. <b>Head Injury</b> Due to (or as a consequence of):		
	Sequentially list conditions, b		
ted Insit	cause. Enter Underlying Cause (Disease or high y that initiated		
d ansit	events resulting in death) Last  Due to (or as a consequence of):  d.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit completely filled in by the funeral director, page 2 should be detached for use as the burial transit.	x UNPENDED AMENDED 23a, pt. II,	27,28a-f,per me,g932 10	)-16-12 sm
Box 68760, e death certificate be the attending physici ed for use as the buri	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		23d. Date of delivery  Month Day Year
x 6876 th certificate trending phy truse as the	past 12 months?  4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	
by the attending pheched for use as the	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
res that the signed by be detach	Chronic Alcohol Abuse		1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been signage 2 should be			24a. Was an autopsy  24b. Were autopsy findings available prior to completion of cause of
Che law			performed?   death? 1 ☑ Yes 2 No 1 ☑ Yes 2 No
icini: The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check only o	one) me 5 Residence 6 ✔ Other: Scene
1 of Vining Physical Chineral direction To	1 V Yes 2 No 1 Impatient 2 Except 27 Manner of Death 28a Date of Injury 28l		Describe how injury occurred
ion c tending eath. tor: Af the fun	1 Natural 5 Pending (Month, Day, Year) 1 X Accident Investigation 1 R 8-30-12 F	a i i vo pm j	ubject fell
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	28e. Place of Injury - At home		Location (Street and Number or Rural Route Number, City or Town, State) 235 Blackberry Ln.
Cospital I hours uncral	ZSG, CORRECT A CONTROL OF A CON	1100	eenstown, MD. to the cause(s) and manner as stated.
To the How within 24 h To the Fur completely	one) 2 Wedical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
F 3 F 3	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
$(l_{\mathcal{O}})$	Tate Unon- Tollel	O.C.M.E.	August 31, 2012
	30. Name and address of person who completed cause of death (Item 23a Patricia Aronica-Pollak MD. Assistant Medical Exa	aminer 900 W. Baltimore Street, Baltir	more, MD 21223
Stat		pare	
Registra	Acres 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy Hadley Smith 2012 September 10:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Roland Park Place If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth Funeral Days (Month, Day, Year) Hours Director 081-01-5781 1 🗆 M 2 💢 F 96 Yrs. June 5, 1916 Georgia Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1

Yes 2 □ No Baltimore N/A Maryland 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a **USA** 21211 830 West 40th Street Apt. 713 items Page 1 and 2 should be filed within 72 hours after death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14 Bace - American Indian Examiner Black White etc. . o. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Black 3 X Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Caledonia Williams Weslev Hector Hadley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 3828 Cherry Brook Road Randallstown, MD Daryl Harrison, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 09/06/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Zhomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland homa 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final EBILITY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine thany, leading to immedicause. Enter Underlying Disable for as a consequence offi Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ubstruction bowel 2 No 3 Probably 4 Unknown Completed osteu novo on-24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{V} \) Residence \( 6 \text{ \text{Other}} \) Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred iniury 5 Pending 24 hours after death. Funeral Director: Al Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35102 Helll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ettaries Street Baltimore Maryland North 00 31. Date filed (Month, Day, Year) State 1

Registrar

SEP 1

arke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 6, 2012 Physician/ Lois V. Smego 8:05 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Paradise Assisted Living 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Director 318-12-0430 90 1 □ M 2 🗶 F Aug. 12. 1922 **Tllinois** Usual Residence of Decedent 28a-f show 10c. City, Town or Location must be notified at Director 1 Yes 2 XNo Lackawanna Clarks Summit Pennsylvanila 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Funeral 18411 USA 702 Shady Lane Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify: white "natural", 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Allegheny General Hospital d Mental Hygiene. marked other than ' Elementary/Secondary (0-12) Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Swenson Bert Sehring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 North Longcross Road Linthicum, Maryland 21090 Raymond Smego Jr. / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 09/07/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stephnaie 22. Name and Address of Facility Cremation Society of Maryland, Inc Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Peath
Service Monday Immediate Cause (Final Physician/ ament disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year g Unknown 9 Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performe Yes 2 X No filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Assisted Other: ₽ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 23365 State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 10, 6:45a 2012 John T. Schroll, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Dunda1k Future Care North Point 8. Date of Birth (Month, Day, ) Jan. 13, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours 1 😿 M 2 □ F 62 T950 Maryland 212-50-1605 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore City Maryland 1 X Yes 2 No n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21205 5039 Orville Avenue 12. Was Decedent Ever in U.S. Armed Forces? 196 1  $\cancel{A}$  Yes  $2 \square$  No  $\cancel{1}$  1 Yes, Give  $\cancel{1}$  1  $\cancel{9}$ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1967-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: white 1973 Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peggy Lynn Green John T. Schroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5039 Orville Avenue Baltimore, Maryland 21205 Laura Schroll/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 09/11/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Marylan , Inc 21. Signature of Eugeral Service Licensee Alyson K Taylor 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner allet Helpile Sequentially list conditions, cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed HTN Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Completed by Physician/Medical Demendia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day Month Yes 2 No 1 ☐ Yes 2 ☐ Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an BBH -After this certificate has funeral director, page 2: autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1-Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1436F00C 09/11/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shuthil Segar - 9813 Walter Wood R. Srik #204. Par Kvill, MD \_ 21234

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Terry 4:38 A.M Sumby 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince Chever by Year If Under 24 Hrs. Social Security Number unk 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Birthplace (State or Foreign Country)unk **Funeral** Months Hours Min. (Month, Day, Year) **Director** 55 1 🖾 M 2 🗆 F Feb 15, 1957 Usual Residence of Deceden 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hyattsville MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20785 1205 Dunbar Oaks Dr. hours after death 12. Was Decedent Ever in U.S. Armed Forces? unk
1 ☐ Yes 2 ☐ No 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Black þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced 16b. Kind of Business/Industry unk 15. Decedent's Education 16a. Decedent's Usual Occupation unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiens is marked other th unk unk other traumatic event, Be unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jaime Sumby - nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Signature of Funeral Service licens 1140 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician myo cardial acute disease or condition Medical resulting in death) Examiner congestiv Sequentially list conditions Examiner Due to (or as a consequence of): it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and burial-trar resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death been signed by the a should be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital 2 1 No Other: 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ours after death.

leral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

M.D

Mosoita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

Stahl

31. Date filed (Month, Day, Year)

072750

August 29, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul D	ouglas S	pitle	1- For State	State of Ma	aryland / De <sub>l</sub> C	partment of <i>ertificate</i> of		d Mental H		201	2 2892
Physicia Medical Examin			1. Decedent's Name (First Paul Doug	1	itler				2. Date of Death Month D September 6	av Year	3. Time of Death 0716 hrs
A SECOND	-		4a. Facility Name (if not in 2111 Bellvale Ro	stitution, give street			b. City, Town, or Fallston	Location of Deat		4c. County of Deat	
	Funeral Director		5. Social Security Number 217-74-711	6. Sex		s. last birthday) Yrs.	If Under 1 Year Months Days		,	MM/DD/YYYY) 9. Bi	rthplace (State or gn Duntry)
Baltimore, MD 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	20a. Method of Disposition	Divorced If Yes, G or Dates on (Specify only higher (0-12) Coll distinctionship (Type, Pringle of the College o	as Decedent Ever in ned Forces? Yes 2 No No No Year st grade completed) ege (1-4 or 5+)  Op 1 1 20t  Oval from State	16a. Decedent during mo	Decedent of His specify Cuban Yes 2 No 's Usual Occupation of working life.  Address (Street Common (Name of center place)  The specific of th	panic Origin? (S, Mexican, Puerti specify: ion (Give kind of DO NOT use re  18. Mother's Nam  Bobbit and Number or netery.	Specify Yes or No- o Rican, etc.)  work done tired)  te (First, Middle, Mai  Rural Route Numbe  Lace School School  Date  2 2 4 4 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Citizen of What Cou  14. Race - Amer White, etc.  Specify: W  3b. Kind of Business/  Com  den Surname)  Manle  r, City or Town, State	rican Indian, Black,  Phite  Industry  Paint  pany  a, Zip Code)  1 Our T  Town, State  MD
1		o Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disea failure. List only one Immediate Cause (Final d or condition resulting in do Sequentially list condition if any, leading to immediat cause. Enter Underlying (Ulbasas or injury that initievents resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?	cause on each line. Isease a. Oxyc Due to (comparison of the comparison of the compa	odone Into or as a consequence of the consequen	e of):  e of):  II,27,28.  egnancy	a-f,per		10-2-12	S <b>m</b> 23d. Date of deliven	Approximate Interval Between Onset and Death  Y Day Year
Division of Vital Records, P.O. Box			Part II. Other significant of Hypertensi  25. Was case referred to nexaminer?  1  ves 2  No 9	Unknown 9 onditions contribute Athero	Unknown ting to death but not sclerotic	t resulting in the ur	ascular 26.Place	Disease of Death (Check	1 Yes 2  24a Was an autopsy performe 1 Yes 2  only one)	24b. Were au	pably 4  Unknown  utopsy findings available completion of cause of the second s
Division of \		Medical Certification: To	27. Manner of Death  1 Natural 5  2 Accident  3 Suicide 6  4 Homicide  29a. Certifier 1 Certify one) 2 Medica	Pending Investigation Could not be determined (Sp. Ing Physician: To the ingent Examiner: On the band man	Date of Injury (Month, Day, Year)  1 9-6-12  Place of Injury - At ecify) Single the best of my knowle	28b. Time of Inj fd 07:0 home, farm, street Family edge, death occurre	8 am 1 Ye , factory, office bu Home ed at the time, dat	y at Work? es 2 X No uilding, etc.	28d. Describe how subject w drug abus 28f. Location (Stree or Town, State Fallston	rith presc se et and Number or Ru 2111 Bell	ription ral Route Number, City vale Rd.
	Ø	Ä	29b. Signature and title of  30. Name and address of p  Melissa Brassell,	certifier  Man J M  erson who complete	5		29c. License O.C.M	1.E.		eptember 6, 20	
	S Regis	tate trar	31. Date filed (MS) Pay		32 legistrar's Signa		Laminole St	reet, Dalline	JIG, IVID 21223		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Zilla Saunders September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a 1338 N. Freemont Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 1 □ M 2 🔏 F Director 219-04-9193 **-15-1929** Trinidad 83 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 1338 N. Freemont Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 XNo 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Damestic Self Employed 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Agatha Mangot Stanford B. Pemberton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1338 N. Freemont Ave., Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) Clara V. Saunders/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-21-2012 San-Fernando, Trinidad Paradise Cemetery 22. Name and Address of Facility Wylie Funeral home P.A. of Balto. Co. Signature of Funeral Service Lie 9200 Liberty rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a considuence of burial-transit Due to (or as a consequence of) resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be exerged hours after death.

24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician letely filled in by the funeral director, page 2 should be detached for use as the burlal. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ NO To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 30. Name\_and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

			Please	Type or Prin							•		•			
For State of Mary  1 - Registrar					arylan	yland / Department of Health and Mental Hygiene										
	1. Decedent's Name (First, Middle, Last)				Certificate of Death					2. Date of Death 2 3 2 import De						
ı	Physici /Medic					I. SMITH				Month	28 <sup>Da</sup>	201 <sup>Year</sup>				
*	Examiner 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Local			Death		4c. County of Death						
	1331 Santa Anita Rd  5. Social Security Number   6. Sex   7. Age (In			a //a . wa	Laurel (In yrs. last birthday)   If Under 1 Year   If Under 24 H				tHre Io	. Date of Bir			thplace (State or I			
	Funeral Director			_м № г /	91	Yrs.	Month			Min.	(Month, D	ay, Year)	1920	Wash.	_	
	pur »		Usual Residence of Decedent  10a. State 10b. County			Taum and a					, ,					
	Maryla f sho	ō	MD PG	10c. City, Town or Location							10d. Inside City 1, Yes 2					
	r 28a-	Director	10e. Street and Number			Laurel 10f. Zip Code					1	10g. Ci	Δ.			
	th with	rai D	1331 Santa Anita Rd			20			708				US			
	er dea items	Funeral	11. Marital Status  1			S. 13. V	<ol><li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li></ol>			n? (Speci Puerto Ri	fy Yes or No can, etc.)	0-	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at a one.	þ				1	1 ☐Yes 2 No Specify:						Specify: Black			
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Baltimore, Maryland 21215-0036	Pages ment of ant: If Ite		20a. Method of Disposition  ★○Burial 2 □ Cremation 3 □			Place of Disposemetery, crem				Dat			ocation - City o			
<u>=</u>	permit. Page Department of Important: If any injury of		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	14404.						Robert G. Mason F.H.						
Ö	7 E 8 9		Terry A. Aus	stin										DC 2002	0	
Н			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused one cause on each lin	I the death ne.	n. Do not ente	er the m	ode of dyir	ng, such as ca	ardiac or	respiratory a	arrest,		Approximate Interval Betwee Onset and De	en	
	Physician /Medical	B 1/3	Immediate Cause (Final disease or condition resulting in death)			vascu]	lar	Dise	ease					Oriset and De	auri	
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Box 687	eath certificate be e: attending physician for use as the buria	ledic	12.7	d												
30X	ath cer ttendir or use	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?	of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic p			ic pregnancy					23d. Date of de	delivery Day Year			
0	at the dea I by the a stached fo	ysici	1 ☐ Yes 2 ☐ Months : 9 ☐ Unknown	time of death 5 Other (specify)							Month Day Year		ar			
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The low retaining to death but not respond to the political of the politic											24a. Was		24b. Were autopsy findings available prior to completion of cause of		ailable	
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	Attending Physician: It death. ector: After this certific by the funeral director,	Be	25. Was case referred to medical examiner?		26. Place of Death (Check only o											
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Ĭ N	al or Attend after death Director: d in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in the complete of the comple		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	the Ho hin 24 h the Fur	Medical	(Check only one)    Check only one)   Check								e to the cause(s)					
	Vithi Com	Σ	29b. Signature and title of certifier		29c. License number					29d. Date signed (Month, Day, Year)						
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	HILL.		30. Name and address of person who					ntor	Dw	T.0333	201	MD	20707			
	Sta		31. Date filed (Month, Day, Year) SEP 1 1 20	32 Registr	ar's Signa	ture	Man	/	DT,	<u>naul</u>	. C.I.,	TATTA	20101			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 6, 2012 Physician/ 3:48 Mary Carroll Snyder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott City Encore At Turf Valley If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 😾 F (Month, Day, Year)
March 5. Months Days Hours Min. 212-14-1772 93 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Ellicott City 1 🗆 Yes 2 No Howard Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21042 items 23a 11150 Resort Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o, 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates white 1 ☐ Yes 2xxx No Specify: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) B & O Railroad secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Josephine Virginia Whittle John Leo Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 Takoya Drive Ellicott City, MD 21042 daughter Kim Wolf Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State st. Ellicott City, Maryland John Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of FaciliMitchell—Wiedefeld Funeral Home Inc Signature of Fyrieral 6500 York Rd. Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury by the attending physician and tached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of cert

30. Name and address of pe

31 Date filed (Month, Day, Year)

SEP 1

who completed cause of death (Item 23a) (Type, Print)

erron Small		State of Maryland / Depart				ible.		
ciron oman		1- For State	ficate of Death	аг пуу		2	012	2893
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)		2.	Reg Date of Death	J. NO.		Time of Death
edical Exam		Sherron Dwaine Small		S	Month September	Day Ye 5, 2012	ar (	0038 hrs
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center	4b. City, Town, or Location of Baltimore	f Death		4c. County	of Death	
Funeral		Social Security Number		r 24Hrs.   8	Date of Birth	(MM/DD/YYY		ce (State or
Director		218-15-3797 <sub>1</sub> X <sub>M</sub> <sub>2</sub> F 41	Yrs. Months Days Hours		09/26		Foreign Country	MD
y		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location				- 140-	I. Inside City Limits
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ryland a-f sh t onco	cţo	10e. Street and Number	10f. Zip Code		110	g. Citizen of W		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryland Hygien than "ustural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner, must be notified at once.	Director	5412 Seward Ave.	21206				S.A.	
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5-0( iled wi Hygier d other the M		17. Father's Name (First, Middle, Last) Johnny Small				aiden Surname shingt		
121 Id be f fental narkes event,	Be C	19a. Informant's Name/Relationship (Type, Print )						0-1-)
AD 2 shoul h and h and h umatic	To.	Adrian Small(sister)	19b. Mailing Address (Street and Num 5903 Plainfiel	d, Ba	altimo	ore, M	vn, State, Zip ID 212	206
e, e, l and l and Healt litem			ce of Disposition (Name of cemetery, matory or other place)	Da	ate	20c. Location	- City or Tow	n, State
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altir mit. I porta		21. Signature of Funeral Service Licenses	22 the seminary of Bacity		r. Fui	neral	Home	PA
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Physician		23a. Part Enter the disease, or complications that caused the death. D failure List only one cause on each line.	o not enter the mode of dying, such as ca	ardiac or res	spiratory arres	st, shock, or he		oproximate Interval etween Onset and
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wounds (2) to H	lead					Death
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tox 68760, eath certificate bc attending physici for use as the buri	sician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2	pregnancy		Month	Day	Year
Box 68760, death certificate be the attending physical for use as the but	ysic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)					
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He lay	Ē				perform	ned?	death?	2 No
Vital Rec ysician: The I his certificate b director, page	0	25. Was case referred to medical	26.Place of Death (	Check only	one)			<u></u>
Vit.	ToB	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ EF	NOutpatient 3 DOA Other	Nursing Ho	ome 5 R	esidence 6	Other.	
ion of tending Pheat.  to After the funeral		1 Natural - FOMOnth, Day, Year)	Bb. Time of Injury 28c. Injury at Work?  OUND: 1 Yes 2	Isut	Describe ho	w injury occurr	red	
SiOr Attended death ector:	catic	2 Accident Investigation Sep 4, 2012 2	340 hrs	No				
Division of Vital Records, P.O. and or strending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	Suicide Could not be determined (Specify) Townshowns	e, farm, street, factory, office building, etc Rowhouse		or Town, Sta			oute Number, City
Hospit 4 hour Funer	ပ္	4 W Homicide (Specify Townhouse / 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge,						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ledical	one) 2 Medical Examiner: On the basis of examination and and manner stated						use(s)
	Ž	29b. Signature and title of certifier	29c. License number			29d. Date sign		Day, Year)
Sm O		my w	O.C.M.E.			September	r 5, 2012	
011		30. Name and address of person who completed cause of death (Item 23 Ling Li, MD Assistant Medical Examiner 900 W	'	ID 2122	3			
S	ate	31. Date filed (Month Car Year) 32. Red strar's 1	January Daniero, N	144	-			
	-	CERT THIS Chause & St. Party						

DHMH 17 Rev 1/2001 OCME 2006

12-06828 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Adam Francis Szezypinski, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 28934 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Year **Medical Examiner** 1847 hrs September 9, 2012 Adam Francis Szczypinski
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6722 Brentwood Avenue Dundalk **Baltimore County** 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** March12,196 Foreign Country) MD Days Min. Director Months Hours 213-58-4029 51 1X M 2 F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 X No or 28a-f show Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatte event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9039 Cuckold Point Road 21219 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes White 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 No specify: Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Baltimore, MD 21215-0036 WAWA 1yr 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Adam F. Szczypinski Sr. Carol Hagy 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Szczypinski /wife 9039 Cuckold Point Road Balto. MD 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 7 Cremation 3 Removal from State Bayview Crematory 9/11/12 Baltimore MD 4 Denation 5 Other Specify. 22. Name and Address of Facility 300 ame and Address of Facility 300 Mace Ave. Balto Connelly Funeral Home of Essex Balto. MD Essex 21221 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease a Narcotic (Morphine) Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate nause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - trans Physician/Medical AMENDED 23a,pt.II,27,28a-f,per me,g931 9-18-12 sm X UNPENDED The law requires that the death certificate be Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Vear past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Liver Cirrhosis Completed Division of Vital Records, peen: page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed?

Yes 2 No death? this certificate 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural Director: 5 Pending 1 Yes 2 X No fd 9-9-12 fd 18:40 pm Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6722 Brentwood Ave. Dundalk, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide (Specify) Single Family Home within 24 hours at determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aulto O.C.M.E. September 10, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) gistrar's Signature State

ORIGINAL

Registrar

12-06744
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Josefa Dolores Sa		chez State of Maryland / Department of Health a  Certificate of Death	and Mental Hyo	jiene	20!	2 2002
Physician		Registrar  1. Decedent's Name (First, Middle,Last)	2	Reg Date of Death	. No. <u>LU</u>	3. Time of Death
Medical Examine	er	JOSEFA DOLDRES SANCHEZ		Month September	Day Year 6, 2012	1510 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, 12300 South Hampton Bishopville	, or Location of Death		4c. County of Death Worcester	
Funeral	٩	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yr		8. Date of Birth	(MM/DD/YYYY) 9. Bird	hplace (State or
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212 wild be Menta marke	99 01	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Str.	reet and Number or Rur	al Route Number	er, City or Town, State	Zip Code)
Dre, MD 21215-0036 sel and 2 should be filed within 72 of Health and Mental Hygiene. If fitem 27 is marked other than " her traumatic event, the Medical 1	Ĺ	ALEJANDRINA RAMBRO 1838 GRANT	TST, HARY	215000	IRG VA. 3	22802
ore, MI ss I and 2 s of Health a of Hiem 27 If item 27	- 1	20a. Method of Disposition  20b. Place of Disposition (Name of or crematory or other place)  Removal from State	cemetery,	)ate :	20c. Location - City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	1	4 Donatton 5 Other Specify: TAMI / GAME IS	By SEPT,	19,2012	HONDUR	16 CA
Baltim permit. Pag Department Important: injury or o		21. Signature of Funeral Service Isoneee 22. Name and Addre	e of Facility	FIELDA	LAN 1859	BALTI MD
Physician	+	23a. Party enter the disease, or complications that caused the death. Do not enter the mode of dying	ng, such as cardiac or re	espiratory arres	shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Myocarditis				Between Onset and Death
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ViSic or Atte fer der fer der in by ti	3	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	e building, etc. 28		eet and Number or Rur	al Route Number, City
Division or Spital or Attending hours after death. neral Director: After filled in by the funer	5	4 Homicide determined (Specify)	940	or Town, Stat	е)	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion			•	
To the Hc within 24 To the Fu Completel	20	and manner stated.	ense number		9d. Date signed (Mon	
		(1/1 ) 10 0.0	C.M.E.		September 7, 20	
OFpend	4	20. Name and address of person who completed cause of death (Item 23a)				
			re Street, Baltimor	e, MD 2122	3	
Stat Registra	_	31. Date filed (Month, Day, Year)  SFP 1 1 2012  SEP 1 1 2012		C	CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPT Year )ANDA 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Augsburg Luthern Nursing Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) Days 85 Director 217-40-6336 1 □ M 2 🔀 F Feb. 4, 1927 Poland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 South Ann Street Apt. 412 21230 Poland items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Specify Caucasian Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the ulth and Mental Hygien 27 is marked other t r traumatic event, th unk unk Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Witold Szulc Anna Otolinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 8523 Creek Rd. Pasadena, MD 21122 Patricia Bensinger/neice 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State Final Journey Crematory 9/11/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature f neral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused tile death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PIRATION INEUMONI A disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 mo 1 Yes 2 N 9 Unknown jo Month Dav Year the a Pregnant at time of death Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's Other 횬 2/ No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident s after death I Director: / Investigation filled in by the 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. the only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (

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30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 Day Cheryl Schaeffer 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death nn 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Birthplace (State or Foreign Country) Funeral Hours Director 217-42-9222 1 □ M 2 🔀 F Maryland 69 09/04/1943 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Gambrills 1 Yes 2 X No MD Anne Arundel ö 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? items 23a Funeral 21054 206 Mustang Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force 0 Black, White, etc. δ 1 Never Married 2 X Married 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Science Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blickenstaff Schaffer Maynard Anna Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other tran Charles E. Schaeffer Jr./Scouse 206 Mustang Court, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 09/10/2012 Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lide 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ mrtastahic disease or condition ntnu Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami igned by the attending physician and be detached for use as the burial-transit Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 2 HO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 🗌 Yes ဂ္ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 or Attending Physician: after death, s after death. I Director: Aft completely filled in by To the Hospital or within 24 hours a To the Funeral D

29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#17,18perFH, G931,9/14/2012, WS
State of Maryland / Department of Health and Mental Hygiene 2012 28938 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07 Pay 2012<sup>ar</sup> 097th Bertha Lee Smith 3:58 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year) 220-22-3438 Director 86 1 🗆 M 2 🔀 F Yrs. 12/07/1925 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 28a-f 1 Yes 2 No MD Harford Abingdon 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 311 G Tall Pines Ct. 21009 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces Black, White, etc. Completed by 1 Never Married 2 🔀 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give White 3 Divorced Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Printing & Mailing Lewis Advertising Be 17. Father's Name (First, Middle, Last)
Linwood Shifflett . Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname)

Josephine Unknown

- Unknown ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Smith - Spouse Bll G Tall Pines Ct., Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial, 2 Cremation 3 Removal from State Gardens of Faith 09/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD of Funeral Service Licenses Schimunek Funeral Home, 21. Signatur 22. Name and Address of Facility 610 W. MacPhail Rd., Bel Air, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ E SA NO PO disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗍 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 9 | Unknown Division of Vital Records, P.O, ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 2 No 1 Yes filled in by the funeral director. Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ I Impatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Number Prantitioner: Thank best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certiful 29d. Date signed (Month, Day, Year) D0056296 - 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 HPPER CHESAPEAKE DR. BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) State Jacks

Rogistrar

SEP 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Serna September Physician/ ICTOR 5:05 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17209 Hunter Green Road Upperco Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min. (Month, Day, 218-03-2533 91 Director 1 🛛 M 2 □ F 01/16/1921 Yrs. Maryland 27 is marked other then "natural", or items 23e or 28a-f shov traumatic event, the Modical Examiner a set by notined at be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Upperco 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17209 Hunter Green Road 21155 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 X Yes 2 □ No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates. WWII 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 9 years Sales and Service Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Settimo Ruini Ginevra , Page 1 end 2 should b tment of Health and Mei tant: If Item 27 is mark jury or other traumatio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17209 Hunter Green Rd. Upperco, Md. 21155 Mrs. Agnes M. Serra (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, permit, Page Department of Important: If eny injury or once. Oulaney Valley Mem Gdn 09/10/12 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 York Road 8000C Gardner Ruck Towson Funeral Home, Scott P. Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ettending physician end I for use as the burial-transi or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the to be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ icate has been sign, page 2 should b Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 뎯 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours e

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Ch the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certif eath (Item 23a) (Type, Print) S. Main St 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g931 9-28-12 yt State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\square \cap \square$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death TIMOR **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours Min. (Month, Day, Year) 118-34-9719 Director 1 XM 2 □ F 66 /14/1946 New York r than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3819 E. Joppa Rd. Apt. 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ 1 Yes 2 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ent: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) aborer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) **Oleanda** C. Wolfe Lester R. Seaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 Shawnna A. Seaman/Daughter 4155 Maple Path Circle, Nottingham, MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ò cemetery, crematory or other place Department of Important: If eny Injury or 9/10/2012 Baltimore Crematory Signature of Full eral Service 22. Nampe and Address of Facility
Parkview Funeral Home & Cremation Service Harford Rd, Parkville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final puto cellula Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Exter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Year the detached 9 Unknown completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No ည 1 🗌 Yes Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, Statel Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only on and title of certifie 29b. Signatu 29d. Date signed (Month, Day, Year) e and addres of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28941 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Sellers Month 6:000 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/13/1939 **Funeral**  Birthplace (State or Foreign Country) Hours Director 1**№** M 2 🗆 F 162-32-1362 Pennsylvania 72 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N☐ Yes 2 ☐ No MD **Baltimore** Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4511 Robosson Road 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 Novy Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Divorced 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard <u>Service</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic John Addison Sellers Viola Blanche Litke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sellers / Brother Quail Hill Ct., Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Chesapeake Crematory 9/8/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Lymphory tic Leuremin Chronic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executives) Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other Specify + nospice 잂 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier no Rajapanemo 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRMAPAKSEMD 7835 SIMIMAN 5-203 Baltimore MO 21209 NSRNapaksemo 2835

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla Registrar		artment of Health ar <i>rtificate of Death</i>	, ,	leg. No. 201	2 28942
I	Physicia		Decedent's Name (First, Middle, Last)  Alberta Simmons			2. Date of Dea Month September		3. Time of Death
Nier	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of [		4c. County of Deat	11:48p <sup>M</sup>
-2.0	ν 		10101 Governor Warfield Pkwy; Apt 161  5. Social Security Number 6. Sex 7. Age (in vrs.	foot Fieth de 1	Columbia  If Under 1 Year   If Under 24	Ula La para de la companya della companya della companya de la companya della com	Howard	
	Funeral Director		214-24-3180 1 D M 2 🖾 F	35 Yrs.		Min. 8. Date of Birth (Month, Day, October	Year) 9. Biri 30,1926	thplace (State or Foreign untry) Virginia
	and show	'n	Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or Lo	cation			10d. Inside City Limits
	Maryle 28a-f s otified	Director	Maryland Howard	Cc	olumbia			1 ☐ Yes 2 🕱 No
	ith the	ralD	10e. Street and Number 10101 Governor Warfield Pkwy; Apt 161		10f. Zip Code 21044		10g. Citizen of What Co	
	death w	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - Ame	rican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 € Year or Dates.		Yes 2 No Specify:	dorto Filodifi, etc.,	Black, White Specify: Nati	e, etc. Lve American
15-0	'2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of	f working	16b. Kind of Business	
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nd	filed v al Hyg d othe	o Be	17. Father's Name (First, Middle, Last)		18. Mother's	s Name (First, Middle, M	faiden Surname)	
Maryland	d Ment marke matic	υ	Jonny White	1		Elizabeth Tov		
	d 2 sho alth an 27 is I	- 1	19a. Informant's Name/Relationship (Type, Print) Alvin Ray Simmons (Son)		ng Address (Street and Number o Springdale Avenue		City or Town, State, Zip Paryland 21207	
Baltimore,	of Hear or othe		20a. Method of Disposition 1 IX Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispos	sition (Name of natory or other place)		20c. Location - City or	
<u>ti</u>	iit. Pag irtment irtant: njury o		4 ☐ Donation 5 ☐ Other (Specify) Man	ryland Na	ational Cem 9		Laurel, Maryl	
Ba	Depar Depar Impo any ir		21. Signature of Fundral Service Licens	22	. Name and Address of Facility 5555 Twin Knolls Ro	Witzke Funera ad Columbia,	al Homes, Inc. Maryland 210	)45
يتاني	Physician/		23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause or ach line. Immediate Cause (Final disease or condition	th. Do not ente	^	rdiac or respiratory arre		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Tue to (or as a consequence)	uence of :			11/22/	- WCC
	7 4	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	uence of):				-
	ecuted and II-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last  C	uence of):				
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Box	the death certificate be executed by the attending physician and iched for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	al death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ds, P.O	To the Hospital or Attending Physician: The law requires that the der within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the accompleted filled in by the funeral director, page 2 should be detached	ed by P	Part II. Other significant conditions contributing to death but not res	sulting in the ur	nderlying cause given in Part I.		acco use contribute to	the cause of death?
Vital Records,	The law recate has be page 2 sho	Completed by				24a. Was ar autops perforn 1 \square Yes 2	y prior to c ned? death?	opsy findings available ompletion of cause of
Ita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 1 Yes 2 XNo Hospital:		26. Place of Death (0	Check only one)		
o <u>+</u>	g Physer this seral di	e: 10	27. Manner of Death 28a. Date of injury	28b. Time of	t 3 □ DOA 4 □ Nursir 28c. Injury at	ng Home 5 Reside	nce 6 Other (Special	·y)
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Division of	alor At safter o il Direct ed in by		4 Homicide determined 28e. Place of Injury - At he building, etc. (Specify		et, factory, office	28f. Location (Str City or Town,	eet and Number or Rura State)	al Route Number,
	Hospit 24 hour Funera leted fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination on the basis of examination of the basis of the bas	n and/or investi	gation, in my opinion, death occur	red at the time, date and	I place, and due to the co	ause(s) and manner stated
	To the Complete Compl	2	only one) 3 ☐ Certifying Nurse Practioner: To the best of m  29b. Signature and title of certifier	y knowledge, de	29c. License number		eause(s) and manner as selected. Date signed (Month,	
			· Hulda Hirkh	an, Mi	D. D433	23 5	eptembe	2× 4,2012
			30. Name and address of person who completed cause of death (Item	1 23a) (Type, Pr	Jap BEDA!	ALTOK.	HAN MT	210414
	Stat Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signal	ture back		11-01-011	HILL THE	TT
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	/larylan					and M	ental Hy	giene	2012	2 2894;
			Registrar  1. Decedent's Name (First, Mid	dle, Last)		Cer	tificate	OID	eatn		2. Date of De	Reg. No.	2012	
	Physicia Medic		Nicholas		Sto1z	enbach					Septem		. 20 Year	3. Time of Death  2:40 A M
- 36.	Examir		4a. Facility Name (if not instituti		_			Town, or l	Location o	f Death	r		ounty of Death	
-			2510 Westches	ter Avenue					City			Ho	ward	
	Funeral Director		5. Social Security Number 214-24-5416	6. Sex 7. A 1 ☐ M 2 ☐ F	.ge (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir Dec. 1	th 1 <sup>1</sup> ,1928	9. Birth	place (State or Foreign Tand
	ld now it	Ļ	Usual Residence of Decedent  10a. State 10b. Coun	tv	10- 04-	, Town or Loc	-11							
	arylan a-f sk fied a	Director	Maryland Howa											10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28 e noti	ĕ	10e. Street and Number	.ru	EII.	icott	10f. Zip	Code				10a Citizer	n of What Cou	
	with s 23a ust b	Funeral	2510 Westchest	er Avenue			210	43				USA	TO WHAT OOG	itu y r
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Baltimore, Maryland	uld be d Menta narkec	2		zenbach					Edit		leushew			
Ma	12 sho llth and 27 is r r traun		19a. Informant's Name/Relation Phillip Stolze										vn, State, Zip	Code) ID 21043
ore,	1 and of Hea fitem		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name	e of	<u> </u>		ate		ion - City or To	
⊏	Pa Interior		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 🗌 Removal from State (Specify)		metery, crem keview	-			/11/	2012	Sykes	sville,	Maryland
Balt	pernit. Der artm Importa any inju once.		21. Signature of Funeral Service	Licensee W01234		22. <b>F</b>	Name and	Address 1 Ho	of Facility	Ste	rling onsvil	Ashton le, In	n Schwa	ab Witzke MD 21228
		Н	23a. Part 1. Enter the disease,	or complications that cause	ed the death.	. Do not enter	the mode	dmon of dying,	dson such as c	Aven ardiac or	respiratory an	tonsv:	ille, N	Approximate
F	Ph <sub>,</sub> sician		snock, or neart failure. List Immediate Cause (Final disease or condition	t only one cause on each lin	ne.	ance								Interval Between Speet and Death
	Medical Examiner		resulting in death)	a. Due to (or is	a conseque									22 413
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):							-	
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689	ath certifica attending p	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								234	. Date of delive	on,
Box 687	death ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant a			Ectopic pre Other (spec					230.	Month	Day Year
P.O.	raf the der d by the detect	Phy	g ☐ Unknown  Part II. Other significant condit		out not resul	lting in the un	derlying ca	use diver	n in Part I	-	220 Did to			5 1 110
Б, Е	To the hospital or Attending Prlysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	COPD					9		!		es 2□N		ne cause of death?
Sorc	iw req is bee 2 shou	plet									24a. Was a			osy findings available
Be.	Fnysician: The la r this certificate ha ral director, page?	Som				-					autop perfor	med? 2 No	death?	mpletion of cause of 2 ☐ No
ita .	certific ector,	Be	25. Was case referred to medica examiner?	l Hospital:				1	e of Death	(Check o	nly one)			
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Division of Vital Records,	al or Attending From States death. Il Director: After the din by the funera	Certificate:	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide deter	d not be mined 28e. Place of Inju- building, etc		ne, farm, stree	et, factory, c	office		28	Bf. Location (S: City or Town		mber or Rural	Route Number,
Δ ;	spiral lours a		29a. Certifier 1 Certifyin	g Physician: To the best of	my knowled	dge death or	cured at the	e time d	ate and nic	ace and				
3	in 24 h	Medical	(Check 2 LI Medical	Examiner: On the basis of e	examination a	and/or investic	ation, in my	opinion.	death occu	urred at th	e time date ar	d place and	due to the cal	see(s) and manner stated
,	Muit Con		29b. Signature and title of certife	Land IN	77)		29c. L	icense n	umber				gned (Month, E	Day, Year)
			30. Ame and address of person	who gompleted cause of d	leath (Item 2	(3a) (Tyne Pri	nt)	DIO	358	<i>T</i>		Sep	T. 4	2012
+1		$\Box$	Kaul Gor,	mley 90	0 C	aton	Av	e	Ba	Itin	nore	MD	21	229
	State Registra		31. Date filed (Month, Day, Year)	2012 32/ Registra	ar's Signaty	par	Kad							
DUIL	1.09.500	ng.	APL 2 2	COLL TOWN		-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARILYN D, THOMPSON SEP 14:20M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 471-34-2803 Director 1 □ M 2 🛛 F 76 March 22, 1936 Minnesota Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No Maryland Elkridge Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5888 Wisper Way 21075 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Mamied 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 v No Specify: If Yes. Give 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " NASA - Hubble Space Elementary/Secondary (0-12) College (1-4 or 5+) Program <u>Purchasing</u> Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vernon Jempsa Ida Matsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s Eric Dickinson/ son Old Scaggsville Road Laurel, Maryland 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If is
any injury or c 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 109/07/2012 Baltimore.Marvland 21. Signature of Fureral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc tephonic 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Subarachnoi disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' ☐ Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 🗌 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0033768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CORWIN 5755 columbia. 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPT Physician/ 1055P DAT TRAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Of Columbia Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 214-15-3467 **Director X**□ M 2 □ F 90 Yrs Jan 10, 1922 Vietnam Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia 1 ☐ Yes 2X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21044 6334 Cedar Lane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 XNo Specify: Completed 3X Widowed 4 ☐ Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hao Tran Luong Nguyen permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hai Nguyen, Brother in law 10214 Feaga Farm Court Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 09/10/12 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician/ ARDIO MY OP ATHY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure to Mive 1 Yes 2 No 3 Probably 4 Unknown dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? 2 UNo 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: No No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this nin 24 hours after death.

the Funeral Director: After this

apletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Tertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier speple MD 00053150 9650 Senhagold Columbia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NID Pup Le alwnma 31. Date filed (Month D. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anna Rose Terry 4:25p Sept 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number 212-09-7422 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Feb. 8, 1921 Director 91 1 □ M 2 🛛 F MD Usual Residence of Decedent ahov 2 should be filed within 72 hours after death with the Maryland th and Martel Hygiene. 27 is marked other then "naturel", or itema 23e or 28e-f aho traumatic avant, the Modibal Examiner mast be nothed at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 904 Boundbrook Way 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates 3 🖾 Widowed 4 🗆 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Worker 12th Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ferdinand Klapka Anna Landa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Paga 1 and 2 sh Dapartmant of Haalth ar Important: If Itam 27 is any injury or other trau Linda Boswell /daughter 3610 Galloway Road Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 9/10/12 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 Donation / 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ WOME OBSTUCTION disease or condition resulting in death) 254 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, dramy, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attanding physician and for usa as tha burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 13 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day cata has baen signad by tha a paga 2 should ba detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificata Yes 2 No 1 Yes funaral diractor, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 s of person who completed cause of death (Item 23a) (Type, Print) N. Charles HALLES W 6701 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28947 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 Year Amelia Taylor Sept. Margaret 3:35 P M Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Co. Towson Gilcrest Hospice Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 216-24-7427 1 □ M 2 🔀 F Director Maryland Dec. 10,1928 83 Usual Residence of Decedent 10d. Inside City Limits er than "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location Director Dunda1k 1 🗆 Yes 2 🔀 No Baltimore MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral United States 21222 2136 Jasmine Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 11 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Georgia H. Adelsberger Charles R. Hannibal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra L. Weitzell (Daughter) Millersville, MD 8368 Elvaton Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Hilltop Service Corp. 9/10/2012 Towson, Maryland 4 Donation 5 Other (Specify) 2 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Signature of Funeral San Licensee who 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequen of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ng physician and es tha burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending for usa es IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ myocardial injunction, sepsi 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed osmown Difficule 24b. Were autopsy findings available prior to completion of cause of 24a Was an

Division of Vital Records, P.O. Box 68760%ata has baan signed by tha a paga 2 should ba datached To the Hospital or Attending Physician: Tha within 24 hours after daath. To the Funaral Director: Attar this certificate I complately fillad in by the funaral director. pag Be ဂ္ဂ Certificate: I or Attending P

performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29c. License number

Charles

29d. Date signed (Month, Day, Year)

JONSON

MO

2012

0

Medical

(Check

31. Date filed (Month

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25, PER ME G931 9/5/12 TRT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 22:38 Rosa Mae Thompson August 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death c.f Hospi ful Baltomore Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 215-74-2213 55 Director 1 🗆 M 2 🖾 F 10/15/1956 Maryland 28a-f shov 10a, State the Medical Examiner must be notified at 10c. City, Town or Location Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2406 Shirley Avenue 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give should be filed within 72 hours after cand Mental Hygiene. Is marked other than "natural", or is 1 Never Married 2 12 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/IndustryBalto. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 21/<sup>Gollege (1-4 or 5+)</sup> years Elementary/Secondary (0-12) Authority Clerk Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Lee Ernest Goings Rosa Lee Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 Is any Injury or other trau Willis Thompson/husband 2406 Shirley Avenue Baltimore MD.21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Bayview Crematory 8-30-12 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 Nac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Brain disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): CAL EXAMINER or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and I for use as the bunal-trar ION ASPROVED BY Due to (or as a consequence of) resulting in death) Last CERTIFICATI Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the at Id be detached fo 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Cardidnyapathy Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNO မှ 1 Anpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18239 MD Angust 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Contino Hospital of 31. Date filed (Month, Day, Year) SEP 11 2012 2. Fegistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 9, 2012 3:30 P M Lily Teachman Bruce Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min 215-28-7505 Director 1 □ M 2 🗓 F 82 Yrs. 3, 1930 Maryland er than "natural", or items 23a or 28a-f show 10b. County filed within 72 hours efter death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1321 Burleigh Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces2.
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Spice Company Be 17. Father's Name (First, Middle, Last) of Heelth end Mantal H fitem 27 is marked of r other traumatic ever 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Page 1 end 2 should be **Edward** Clingman Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Wilbur R. Teachman 1321 Burleigh Road Lutherville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 = 6 1 Burial 2 X Cremation 3 Removal from State Depertment of Important: If any injury or once. 4 Donation 5 Other (Specify) Hilltop Service Corp.: 9-11-2012 Towson Maryland 21. Signature of Funeral Se 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ Onset and Death Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin the Hospital or Attending Physician: The lew requires thet the deeth certificata be executed Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 ☐ Other (specify) Month 1 ☐ Yes 2 ☐ No eral Director: After this certificate has been signed by the e filled in by the funeral director, page 2 should be detached t 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 10 Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) s efter death. i Director: After the Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours e To the Funeral D completely filled Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATHI KUMAR

DHMH 17 Rev 06-2011

Registrar

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SEP 1 1 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. Tsakalos 20**1**2 6:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Aliceanna Street N/A Baltimore 5. Social Security Number 219-07-9474 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **Director** 1 X M 2 D F 93 Feb. 17 1919 Pennsylvania 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If items 23a or 28a-f sho amportant: If item 27s marked other than "natural", or items 23a or 28a-f sho any hijury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Aliceanna Street 21202 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2X Married by Yes 2 K No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Co-Owner H&S Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Tsakalos Rodanthi Markotsis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Tsakalos / Son 12849 Stone Eagle Road Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Spe In tombment Greek Cemetery 9/10/2012 Windsor Mill, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Sovice Licens 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at work? 1 ☐ Yes Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 5 Pending injury 2 🗌 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: completely filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. (Check the 29d. Date signed (Month. Dav. Year) State Registrar

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			For State	State of Marylar				Mental Hy	giene	10 000EL
			Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> )	Cer	tificate of D	Death		Reg. No. 2 U	12 28951
- v	Physicia Medic	al	EDWARD	VERNA	tec i			2. Date of De Month	Day Y	ear 3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give  Union Memorial  5. Social Security Number  6. Se	2 Hospital	t A birth-de-N		more		4c. County of	
	Funeral Director			7. Age (In yrs. 92)		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birl (Month, Da Oct	19, 1919	). Birthplace (State or Foreign Country) Pennsylvania
	/land f shov ed at	tor	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation	<u> </u>			10d. Inside City Limits
	e Mary r 28a- notifie	Sirec	MD 10e. Street and Number	I	Baltimo					1 🄀 Yes 2 □ No
	with th	iral	3838 Roland Ave	Ant 1011		10f. Zip Code 21211			10g. Citizen of Wha	at Country?  States
	leath v items er mu	Fun	11. Marital Status	12. Was Decedent Ever in U.		Vas Decedent of His	spanic Origin? (St	pecify Yes or No-		American Indian,
21215-0036	e flied within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates.	1	Yes, specify Cubar  ☐ Yes 2 ☑ No		o Rican, etc.)	Black, \ Specify:	White, etc. White
15-(	72 hou n "nate ledica	plet	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give k	ent's Usual Occupa ind of work done de		king	16b. Kind of Busin	ess/Industry
212	ed within Hygiene. other thar ent, the N		Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired)			Carpet	
Maryland 2	be filed vental Hygeked other	To Be	17. Father's Name (First, Middle, Last)  Quinton Vernaco	hio				me (First, Middle, Donato	Maiden Surname)	
aryl	1 and 2 should be file f Health and Mental item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Ty		19b. Mailin	a Address (Street a	_		r, City or Town, State	e Zin Code)
-	and 2 st Health a tem 27 is		Joy B. Vernacchio	/Wife						e, MD 21211
Baltimore,	age 1 and ent of Hea nt: If item y or other		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	cemetery, crem	sition (Name of latory or other place ake Crema		Sep 09	20c. Location - Cit	ty or Town, State
Baltii	permit. Page 1 an Department of He Important: If iten any injury or oth		21. Signature of Funeral Service Licens			Na <b>Cremad</b> ee	mof Family Fu	neral Alt	ernatives	
			23a. Part 1. Enter the disease, or comp	lications that caused the deat	th. Do not ente					ryland 21286 Approximate
	Ph_sician/		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	37) V	= Itom	OT F	K12 08	0-	Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a conseq	uence of):	1 400	-0.1	0 10 0		1100
	Lxammer	er	Sequentially list conditions,	b. Due to (or as a consequence)	VIRI	INH	Hay	1)150	150	5 4/28
	ted 1 ansit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence oi):					
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09	ate be shysici the bu	dica	•	d						
687	ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancv				1	
Box	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Completed by Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date o Month	f delivery Day Year
P.O.	that the ned by e deta	y P	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
ds,	requires been sig should b	ted t	MIKINZ	+ (BRIL	LA	TION		1 🗆 1	/es 2□No 3	Probably 4 Unknown
Division of Vital Records,	sician; The law re s certificate has be director, page 2 sh	omple						24a. Was a autop perfor	sy prior deat	e autopsy findings available r to completion of cause of th? Yes 2 □ No
tal	ysician; is certifica director, I	Be	25. Was case referred to medical examiner?	lospital:			ce of Death (Chec		2/23/40/	163 2 110
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o uc	nding ath. :: After ie fune	icate	1 Natural 5 Pending Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 🗆 Y		28d. Describe h	ow injury occurred	
ivisio	I or Attending after death. Director: After d in by the funer	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Town		r Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	Medical	(Check 2 Medical Examir	cian: To the best of my knowler: On the basis of examination	n and/or investi	gation, in my opinion	<ol> <li>death occurred a</li> </ol>	at the time, date ar	nd place, and due to	the cause(s) and manner stated.
	To the He within 24 To the Fu	— r	29b. Signature and title of certifier	Practitioner: To the best of r	ny knowleage,	29c. License			ne cause(s) and mann 29d. Date signed (M	
	mhi	ļ	30. Name and address of person who co	umpleted cause of don'th (Itan	239) (Timo D	int)	8-17	<u> </u>	4/ 10/	2016
	1/1,		MANUEL VIE	Atmos, mp	,1200	540R	KFD	#36,4	UTHERL	114 Jugues
	Stat Registra	5	31. Date filed (Month, Day, Year) SEP 1 1 2012	82. Registrar's Signat	bar	W		(		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. Physician/ Day Susan J. Valverde 2012 8 2:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Anne Arundel Harwood Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) (Month, Day, Year) Director 230-84-7321 1 M 2 1 F April 13, Usual Residence of Decedent 1961 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Exeminer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 West Washington Street #302 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 Never Married 2 Married 1 Yes 2X No Black, White, etc. Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rudolph Tess Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Evan Valverde / son 8503 Nogales Ct. Alexandria. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State any injury or o cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/13/12 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ cemic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Lause (Disease or Injury cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of death? autoosy **Director:** After this certificate in by the funeral director, pag 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 14 No Other: 4 Nursing Home 5 Residence မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident 1 Yes 2 🗆 No Investigation after deat Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) e Funeral Di e Funeral Di letely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the 1 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wh d cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State

Registrar

Registrar

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			51. Agres Hos	0/1/Q/ 6. Sex 7. A	an //n ura lant hirt		nore If Under 24 Hrs	8. Date of Bir	db		A
	Funeral Director		216-36-3117 Usual Residence of Decedent	1 D M 2 F	ge (In yrs. last birti	Months Days				2 Sirth	place (State or Foreign try)
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ي	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1  Never Married 2  Marri	12. Was Decedent Armed Forces' ed 1 \sum Yes 2	? /		oan, Mexican, Puert	pecify Yes or No- to Rican, etc.)		Race - Americ Black, White,	
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Mary	should n and M 7 is ma raumat		19a. Informant's Name/Relationsh		19b	Mailing Address (Stree	t and Number or Ru	,		n, State, Zip (	Code)
	1 and 2 of Health item 2 other 1		20a. Method of Disposition	Oruo		Disposition (Name of	284 8 104	Date Date	20c. Locati	on - City or To	bwn, State
Baltimore,	t. Page tment c tant: If ijury or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify	e Garris	y, crematory or other pla Fores	0 : (31	4/2012	DWI	ngs 1	1:11s, MD
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			23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that cause nly one cause on each lin	ed the death. Do n	ot enter the mode of dy	ing, such as cardiad	or respiratory ar	rrest,		Approximate Interval Between
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OFT A Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal death at time of death	3 ☐ Ectopic pregnal 5 ☐ Other (specify)	ncy <b>/</b>	CENTRE STATE	23d.	Date of delive Month	ery Day Year
NO.	that the ned by 1 e detacl	y Ph	Part II. Other significant condition	ns contributing to death	but not resulting i	n the underlying cause o				ontribute to th	ne cause of death?
rds,	equires een sigi ould b	sted						110			bably 4 Unknown
SOD, Marian +	The law nate has b	Comple						24a. Was auto perfo		prior to co	psy findings available mpletion of cause of
ital	sician: certific lirector,	Be	25. Was case referred to medical examiner?  1 1 Yes 2 100	Hospital:	2 5000		Place of Death (Che				
of v	ng Phy fter this ineral d	ite: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of inj	jury 28b. T	ime of 28c. Inju		Home 5 Resi			")
), n	I or Attendii after death. Director: Al I in by the fu	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ation of be	ijury - At home, fai	M 1 0	Yes 2 No	28f. Location &	Street and Nu	mber or Rurai	Route Number,
Uilson, Marian Division of Vital	Hospital or Attending Physician: 24 hours after death: Funeral Director. After this certific stely filled in by the funeral director,	al Ce	/_	building, e	tc. (Specify)			City or Tov	wn, State)		
3	the Hospital	Medical	(Check 2 L Medical Ex	Physician: To the best of caminer: On the basis of Nurse Practitioner: To t	examination and/o	r investigation, in my opir	nion, death occurred	at the time, date a	and place, and	due to the ca	use(s) and manner stated.
	To the within To the comple	_	29b. Signature and title of certifier	9 60 0	24.5		se number			ned (Month,	
	1 824		30. Name and address of person w	ho completed cause of	death (Item 23a) (		00581	71 ]	Hugu	2L 7.2	,2012
	Pp		900 South	Caton A		ltimore	mo	217	229		
	Sta Registra		31. Date filed (Month, Sar Year)	1 2012	we B.	pare					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar					ertificat					Reg. No. 2 (	1	2 28955
Physicia Medic		1. Decedent's Name (First, Midd Clayton D	elber								2. Date of Dea Month Septem	Day	Year 201	3. Time of Death  2 7:45 P <sup>M</sup>
Examin	er	4a. Facility Name (if not institution Frederick				ital			lerio			4c. County Fred	y of Dea leri	th L <b>ck</b>
Funeral Director		5. Social Security Number 193–18–5092	6. Sex	7. A	ge (In yrs. la		Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl	n ; Year)	9. Bir Co	rthplace (State or Foreign ountry)
*		Usual Residence of Decedent  10a. State  10b. Count		12 🗆 📙		Yrs					Dec.11	1924	Pen	nsylvania
/anylan 8a-f sh tified a	recto	MD Frede				y, Town or Adams	stown							10d. Inside City Limits  1  Yes 2 No
th the A 3a or 2 t be no	Funeral Director	10e. Street and Number 3110 Chartwel	1 (700	acout T			10f. Zi	p Code	217	10		10g. Citizen of		ountry?
eath w	une	11. Marital Status	12.	Was Decedent	Ever in U.S	S. 1:	3. Was Dece	dent of His	spanic Ori	gin? (Spe	cify Yes or No-		SA ce - Ame	erican Indian,
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	by	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	arried	Armed Forces  1 X Yes 2 If Yes, Give Year or Dates.	] No	45	If Yes, spe 1 ☐ Yes				Rican, etc.)	Bla	ck, Whit	te, etc.
2 hours "natura	Completed		ent's Educat	tion	1342-	16a. De	cedent's Usu			t of work	ing.	16b. Kind of B		
vithin 7; iene. r than the Me	Com	Elementary/Secondary (0-12)		College (1-4 or	5+)	life	untant	e retired)	uning mos	COI WOIN	ng	Consum	ner 1	Products
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nd Meni marke	۲	Arthur W. War				10) 14	W A .l. A		-		llen Mye	<del></del>		
nd 2 sh saith ar n 27 is er trau		Anne I. Warma					-				ent Ln.			MD 21710
age 1 ar ent of He nt: If iter yor oth		20a. Method of Disposition 1 ☐ Burial 2 🎛 Crematio 4 ☐ Donation 5 ☐ Other		noval from Stat		emetery, c	position (Nai rematory or o	other place	e) atorv		Date 1/12	20c. Location Woodbir	-	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Merical Examiner must be notified at once.		21. Signature of Juneral Service	• • • • • • • • • • • • • • • • • • • •		M01	<u></u>		TACKIE	s of rei	Mati	on Servi	ce P.O.	. Bo	
		23a. Part 1. Enter the disease, a shock, or heart failure. List	or complicat only one ca	tions that cause	ed the deatl								7.1.1	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	Due to (or as	pul	mon	MA	res						Onset and Death
Examiner	_	Sequentially list conditions		Asotro	tion	m	umo	nia						
rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as	a consequ	uence of):	cer							
be executed sician and burlal-transit	cal Ex	that initiated events resulting in death) Last	c	Due to (or as	a consequ	uence of):								
ficate b g physias the k			d											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		If yes, outcoment of Live Birth 4 Pregnant 9 Unknown	2 D Feta at time of d	al death 3	B		у				ate of de onth	elivery Day Year
hat the ed by th detach	y Phy	g ☐ Unknown Part II. Other significant condit		_		ulting in th	e underlying	cause giv	en in Part	l.	23e. Did to	bacco use cont	ribute to	the cause of death?
quires the sign and be	ted b										1 🕪	es 2□No	3 🗆 P	robably 4 🗆 Unknown
The law re ate has be bage 2 sh	Completed								,. <del>.</del>		24a. Was a autop: perfor	sy med?	prior to death?	ntopsy findings available completion of cause of
ician: T	æ	25. Was case referred to medica examiner?	Hosp	nital:					ace of Dea	th (Check		2 LLETNO	T L TES	S Z L NO
g Phys er this o	:e: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	-	1 ☐ Inpa 28a. Date of in	ury	28b. Time		28c. Injury	at ⊔ N		me 5  Resident			cify)
ttendin death. tor: Aft the fur	Certificate:	1 Natural 5 ☐ Pend 2 ☐ Accident Inves 3 ☐ Suicide 6 ☐ Coul	tigation	(Month, D		injun	М		? Yes 2 ☐ ———	-				
oital or A urs after ral Direc			mined		tc. (Specify,	"					City or Towi	n, State)		ral Route Number,
the Hosp hin 24 ho the Fune npletely f	Medical	(Check 2 Medical only one) 3 Certifyir	Examiner:	On the basis of	examination	n and/or inv	estigation, in ge, death occ	my opinio curred at th	n, death oo ne time, da	curred at	nd due to the car the time, date ar ice, and due to th	d place, and du	e to the	cause(s) and manner stated.
o d viti		29b. Signature and title of certifi	y mo				290	DOO	number 73/9	7		29d. Date signe		h, Day, Year) Y 8, 2012
ar /		30. Name and address of person	$\mathfrak{h}.\mathcal{O}.$	leted cause of 400 U	death (Item	23a) (Type	street	F	edel	rick	, mary	land a	217	701
Stat Registra		31. Date filed (Month, Day, Year) SEP 1 1 2	)12 /	32. Regist	rar's Stinat	ture fav	de la							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larence William	n W	ashington 1- For State Registrar	State of	Maryland /	-	artment of rtificate of		and N	/lental l		Reg. No	20	12	2895
Physicia Medical Exami	al 1/	1. Decedent's Name (First CLARENCE W		WASHINGT(	ON					2. Date of De Month August 3	eath		3. Tir	ne of Death 720 hrs
		4a. Facility Name (if not in 4111 Warner Av		reet and number)		4	b. City, Tow Landove		ation of Dea		4	c. County of D Prince Geo		
Funeral Director		5. Social Security Number 7128 231-52-7138	8 1	7. Age	(In yrs. I	ast birthday) Yrs.	If Under 1 Months	_	Under 24H Hours M		Birth (MM	1/DD/YYYY) 9 Fo		
h the Maryland 23a or 28a-f show any setified at once.	Director		County		10c. City,	Town or Location			R HIL	LS	10g. Cit	tizen of What (	1 🏻	Inside City Limits  Yes 2 No
after death with the A al", or items 23a or iner must be notified	by Funeral Dir	4111 Warne  11. Marital Status  1 X Never Married 2  3 Widowed 4	2 Married 1 Divorced If Y	2. Was Decedent B Armed Forces? Yes 2		If Ye	Decedent of second of the seco	of Hispanio uban, Me	xican, Puer	Specify Yes or N to Rican, etc.)	No-	14. Race - Ai White, et	nerican Ind	dian, Black,
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natur or other traumatic event, the Medical Exam	Completed t	15. Decedent's Education  Elementary/Secondary  12 TH  17. Father's Name (First,	r (0-12)	ighest grade comp		16a. Decedent during mo	st of working	g life. DO	NOT use re	etired)		Kind of Busine		y
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To Be C	LEROY WASH  19a. Informant's Name/Re	INGTON	, Print )		19b. Mailing	Address (	I	UCILL	E JACKS	ON	,	tate, Zip C	ode)
E the state of th		SHIRLEY DO	on	Removal from Stat		6238 Place of Disposit crematory or other	ion (Name o			Date AL		NDRIA,		
Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 0 21 Signature of Funeral S	Other Specify:	nelius			ame and Add	dress of F	acility J.	/08/2012 B. JENK	INS	FUNERA	L HON	ME INC.
Physician /Medical Examiner		23a. Part I. Enter the dise failure. List only one Immediate Cause (Final or or condition resulting in d	e cause on each l' disease a. Ath		ardiov	ascular Dise		ying, such	as cardiac	or respiratory a	rrest, sh	ock, or heart		roximate Interval ween Onset and Death
ited J ansit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)	ate Due Cause tiated c	to (or as a consecto (or as a consec		•								
60, ate be executed physician and te burial - transit	Medical	UNPENDED  IF FEMALE:	X AI	MENDED #5pe 3c. If yes, outcome	rFH.	G931.9/2	26/201	2,WS			23	d. Date of deli	/ery	
Box 6876( death certificate the attending physical for use as the b	Physician/Me	23b. Was decedent pregna past 12 months? 1 Yes 2 No 9	_   4		me of de	ath -	al death er (Specify)	3 E	ctopic pregr	nancy		Month	Day	Year
9 - 2	ā	Part II. Other significant	conditions con	ntributing to death	but not re	esulting in the un	derlying cau	ise given	in Part I.	1 Ye	es 2 [		robably 4	4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death.  al Director: After this certificate has been signed by the funeral director, page 2 should be deated.	Completed									1 ✓ Yes	psy orm <u>ed</u> ?	prior death	to complet	ndings available ion of cause of
Vital hysician: this certi	To Be	25. Was case referred to examiner?  1 ✓ Yes 2 □ N	Modical Hosp	ital: 1 Inpatien	t 2 🗌	ER/Outpatient		Other	eath (Check 4 Nursi	ing Home 5	Reside	ence 6 🗸 O	her: Scene	•
tion of trending P death. ttor: After	ation:	27. Manner of Death  1  Natural 5   Accident	Pending Investigation	28a. Date of Injury (Month, Day,Ye:	ar)	28b. Time of Inj	1[	Injury at \	2 No	28d. Describe	how inj	ury occurred		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 4 Homicide 29a. Certifier	determined	28e. Place of Inju						or Town,	State)			te Number, City
To the How within 24 h To the Full completely	Medical	one) 2 Medic	cal Examiner:On	To the best of my the basis of exam I manner stated.	_		on, in my opi	nion, deat	th occurred		and pla	ace, and due to	the cause	
	Σ	29b. Signature and title of	certifier	nat			- 1	ense nun			1	Date signed (		, Year)
81		30. Name and orders of Pamela E. South	nall, MD As	oleted cause of de ssistant Medic			W. Baltim	nore Str	reet, Balt	imore, MD 2				
Sta Regist	ate rar	31. Date filed (Month Par	5°1"1 201	2 32. Registrar's	_	1. ba	Kal			<del>-</del>				

	-	State of Ma  State of Ma  For State Registrar  1. Decedent's Name (First, Middle, Last)		d / Depa		lealth and	Mental Hyo	giene Reg. No	0010	2895
Physicia Medic	al .	Rita Barbara Wel	L1ho	fer				ber Day	y <sub>5</sub> , 2012	3, Time of Death 3:38 P M
Examin	er	4a. Facility Name (if not institution, give street and number)  Rockville Nursing Home			4b. City, Town, or Ro	·Location of Dea ckville	th		. County of Death Montgome	ry
Funeral Director		141-22-9601 1□M2\\F \ 3	In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthp Count New	elace (State or Foreign Inv) Jersey
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomery  10e. Street and Number	10c. City	y, Town or Lo	cation  ville  Tof, Zip Code			10a Cit	izen of What Coun	0d. Inside City Limits 1 ፟ Yes 2 □ No
s 23a c nust be	Funeral	303 Adclare Road				850			ited Stat	-
ral", or item Examiner m	۾	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Every Armed Forces?  1 ☐ Yes 2 ☑ No. If Yes, Give Year or Dates.		1	Nas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - America Black, White, e Specify: Whi	etc.
ne. than "natu te Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)		(Give i life. D	dent's Usual Occup kind of work done o O NOT use retired)	ation luring most of wo	orking		ind of Business Inc	,
Hygien other i ent, th	Bec	10 17. Father's Name (First, Middle, Last)		Hote	L Manager	18 Mother's Na	me (First, Middle, i		spitality	
fental	₽	William G. Wellhofer					thel For		ournamey	
is me		19a. Informant's Name/Relationship (Type, Print)							Town, State, Zip C	
Health em 27 ther ti		Rachel Kruth / Niece 20a. Method of Disposition	onh D	_	sition (Name of	treet, G			, Marylan	
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Impo any i		21. Signature of Functal Service Licensee	4013	05 Ro	bert A. Pun 57 Wisconsi	phrey Fun in Avenue.	eral Home/ Bethesda	Bethe Mary	esda-Chevy vland 20814	Chase, Inc.
ysician/ Medical kaminer	Examiner	23a. Part WEntlet the disease, or complications that caused it shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inipiry)  Dementia	nsiv consequ Vasc	re Hear Jence of): Lular A	t Diseas					Approximate Interval Between Onset and Death
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icate has b r, page 2 st	Completed							sy	prior to con death?	sy findings available npletion of cause of
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tor After this the funeral o	Certificate: T	27. Manner of Death  1 X Natural  28a. Date of injury  (Month, Day, )  2 Accident  Investigation  3 Suicide 6 Could not be	/ear)	28b. Time of injury	28c. Injury work M 1 🗆	at	28d. Describe ho		Other (Specify) occurred	
rurs after o		4 ☐ Homicide determined 28e. Place of Injury building, etc. (	Specify)	)			City or Towi	n, State)	i Number or Rural i	
thin 24 ha	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Check only one) 5 Certifying Nurse Practioner: To the best of my Check of the first few	mination	and/or invest	igation, in my opinio leath occurred at the	n, death occurred time, date and pl	at the time, date an ace, and due to the	id place, cause(s)	and due to the cau and manner as sta	se(s) and manner state ted.
00		29b. Signature and title of certifier  Works V. Jon	1			)47330			e signed (Month, D	
384		30. Name and address of person who completed cause of dea Thomas V. Joseph, M.D. 50 V				, Ste. 2	207, Rock	v <u>i</u> 11	Le, Maryl	and 20852
State	•	31. Date filed (Month, Day, Year) 62. Registrar's	Signati	ure have	V. A					

DHMH 17 Rev 7/2009

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Richard Weller State of Maryland / Department of Health and Mental Hygiene 2012 28958 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner August 27, 2012 1120 hrs Richard Weller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 35 Eastship Road **Baltimore County** Dundalk 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Months Days Hours Min Director Dec. 29,1972 213-80-7673 1 X M 2 F 39 Country) MD Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No ilmore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

That: If firm 37 is nexted other than "natural", or items 23a or 23a-f show or other transmite event, the Medical Examiner must be notified at once. Dunda1k Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 35 Eastship Road 21222 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. Yes 2 X No 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manual Labor Warehouse 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Richard Eugene Weller, Sr. Audrey Lynn Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Eastship Road Dundalk, MD 21222 George Fischer / Brother Baltimore, I permit. Pages 1 and Department of Healt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify Atlantic Crematory 9-5-12 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 SUlphur Spring Road Arbutus, MD 21227 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medica a Methadone Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g931 9-18-12 sm signed by the attending physician be detached for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available performed? death? Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 V Yes After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural subject ingested drug 5 Pending 1 Yes 2 X No Director: fd 8-27-12 fd 11:04 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 35 Eastship Rd. 3 X Suicide 6 Could not be or Town, State) 3
Dunda1k, MD determined Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 28, 2012 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registra

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ sept. 2012 2:04 John Carl Werner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Carroll **Examiner** Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours March Day, Year), 1942 Confaryland **Director** 216-42-7448 1**X** M 2 □ F 70 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 1 ☐ Yes 2 🗓 No Carroll Manchester Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 3780 Hare Drive 21102 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc 9 þ 1 Never Married 2 XMarried filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Seminole County Elementary/Secondary (0-12) College (1-4 or 5+) the Field Service Officer Sheriff Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ Margaret Plumhoff John Carroll Werner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace A. Werner - wife 3780 Hare Dr. Manchester, MD. 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 6,2012 Manchester, Faiths Crematory Sept. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Guth Elhard 3296 Dr. Manchester, MD. 21102 Charmil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consquence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death signed by the at Id be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe this certificate 2 🗌 No 1 Yes Yes 2 Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of De 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 5 Pending injury Natural Accident Investigation completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number Month, Da 29d. Date signed

State

Registrar

ST. WESTMINSTER, MD 2115

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year  $31^{\text{Day}}$ 2:20P Esther Rosedell Roberson Wright August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Svkesville Brinton Woods Nursing & Rehab 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🔀 F North Carolina December 11,1923 88 Yrs Director 245-20-5320 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster 1 Yes 2 X No Maryland 1 4 1 Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 U.S.A. 507 High Acre Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify. 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Analyst NSA Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Creola Clementine Harrison Tommie Lawrence Roberson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Wright (son) 4091 Columbia Drive Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 9-6-2012 Williamson, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Signature of Fune al Service Licen 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ NONE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death led by the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 Yes 2 100 25. Was case referred to medica director. 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: injury Natural 5 Pending Accident Investigation the Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar DHMH 17 Rev 7/2009

only one 29b. Signature and title of certi

31. Date filed (Month

30. Name and

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erson who completed cause of death (Item 23a)

9c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day 5 AM Saniisha 111ams 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard Country Genera Columbia 8. Date of Birth May 7, 1950 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Nov. Vondar **Funeral** 1 M 2 XF New York Director 112-40-4749 62 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Howard Columbia 1 Yes 2XX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 21044 U.S.A. 5313 High Wheels Court items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō 1 Never Married 2 Married þ Yes 2 X No Yes, Give Maryland 21215-0036 1 X Yes 2 □ No Specify: Specify: Puerto Rican 3 Widowed 4 X Divorced "natural" Completed Puerto Rican Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francisco Gaston Juanita Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peru Miles-Vick Williams 5313 High Wheels Court Columbia, Maryland 21044 (Son) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9-7-2012 Glen Burnie, Maryland Signature of Funeral Service Licens 22. Name and Address of Facility Witzke Funeral Homes, Inc. ad Columbia, Maryland 21045 5555 Twin Knolls Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 1911 arond Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The to (or as a consequence of). sician and burial-trans Due to (or as a consequence of resulting in death) Last Physician/Medical that the death certificate be the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No Records, cate has been sig Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, i Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29c. License number 2012 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) September 2012 Physician/ 8:05 PM May Whitehead Beulah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Funeral Hours Director 437-26-7271 1 🗆 M 2 🗓 F **Illinois** October 19,1923 89 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other treumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 1 Yes 2 X No Ellicott City Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21043 8115 Yellow Pine Drive Unit F Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify White 3 x Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lula Howell Everett Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellicott City, Maryland 21043 8115 Yellow Pine Drive Unit F Joe Warren (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Importent: If it eny injury or o 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 9-3-2012 4 Donation 5 Dother (Specify) Atlantic Crematory Glen Burnie, Maryland 21. Signature of Furieral Sance Licens 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RESPIRATORY SECONDARY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ASPIRATION PNEUMONIA Sementially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) been signed by the s should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has baral director, page 2 s autopsy performed? 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accider work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afti completely filled in by the fur Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner To the best of my kind which is death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) of certifié 29b. Signature and titl

DHMH 17 Rev 06-2011

State Registrar CEDAR

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Q. ABBAS

31. Date filed (Month, Day, Year)

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Phys			John Calvin	Adams							August	21,	<sup>Day</sup> 201	2 <sup>Year</sup>		20 ам
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Baltimore, Maryland 21215-0036 oernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", o	other traumatic		19a. Informant's Name/Relationship Loretta Ann Ad			19b. Mailii 7304	ng Addres 16th	s (Street a	and Numb	erorRum Hyatt	Route Numb	er, City • MI	or Town, 3	State, Zip C	Code)	
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So Physicia Physician and Physician and Physician and Physician and Physician and Physician Phys	iner iner	lical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to  Due to	(or as a consection as a conse	Juence of):					dise		J.		Interval B Onset and	etween d Death
P.O. Box 68766 ss that the death certificate igned by the attending physical properties of the propert	ched for use as t	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🔲 Live	tcome of pregn Birth 2  Feignant at time of nown	al death 3	☐ Ectopic☐ Other (s		су					ate of delive	ery Day	Year
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Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been signal.	in by the	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	e of Injury - At h ling, etc. (Specia				iles ZL	_ NO	28f. Location City or To			per or Rural	Route Nu	mber,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#10 eperFH, 8/21/12; BMW, McCo Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Mabel Helen Annell 2012 Medical Auaust 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Village at Rockville</u> Montgomery Rockville Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) ept. 19,1923 Illinois 351-16-1736 Director 1 M 2 F 88 Sept. er then "neturei", or items 23e or 28e-f show the Medical Examiner must be notified at permit. Pege 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hyglene. Importent: If Item 27 is marked other then "neture!", or Items 23e or 28e-f showeny injury or other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1X Yes 2 ☐ No 10e. Street and Number 9701 Veirs Drive 10f. Zip Code 20850 10g. Citizen of What Country? Funeral 14006 Eagle Court 20853 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. à 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 2 XNo 1 ☐ Yes 2 🖾 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Switchboard Operator 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Fred Hartmann Bertha Edecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Rosenthal/Power of Attorney 14120 Bauer Drive, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of August 20c. Location - City or Town, State cemetery crematory or other place). Ceo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) 2012 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 sun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final set and Death Enysician disease or condition resulting in death) Medical u-nde off Examiner Loo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burlal parist 0 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No 2 - N 25. Was case referred to medical æ 26. Place of Death Check only one) examiner? Other မြ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) la 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 Veirs Drive Charles W. Karesh, Rockville, MD 20850 M.D. 31. Date filed (Month, Pay, Year) AUG 21 State Registrar

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Baltimore, permit. Pages I an Department of Hea Important. If itel injury or other tr	1	21. Signature of Funeral Service Licen	See				01100	R.T. Foard	d Funeral H ng Sun, MD	ome, P.A. 21911
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		Pote () -	Polle	- ,_		C	C.M.E.		August 25, 2012	2
	ł	30. Name and address of person who	completed cause of	death (Iten	n 23a)		- Mi	not Dellines 1	ID 21222	
		Patricia Aronica-Pollak M			Examine	r 900 W. B	aitimore Str	eet, Baltimore, M	וט ג וענט	
Sta Registr	ite rar	31. Date filed (Month Day, Year) 201	2 2. Registr	ars Sign	ure Asa					
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			For State Registrar	State of M	laryland		artment of l tificate of i		nd Mer		giene <sub>Reg. No</sub>	ZUI	2	28966
	Physicia	an/	1. Decedent's Name (First, Middle, Last)  MARY PAULINE BROWN  2. Date of Death  Month Day You  A GUST 13 26									Year 26/2		Time of Death 1:30 P.M
na.	Medi √ Examir		4a. Facility Name (if not institution, giv		· · · · · ·		4b. City, Town, c	or Location of		4c. County of Death				1.90 1
	<i>}</i>		Reeders Memoria				Boons			Washington				
	Funeral Director		5. Social Security Number 6. \$ 214-07-6001	Sex 7. Ag I□M2∏XF	je (In yrs. la 93	st birthday) Yrs.	If Under 1 Year Months Days			Date of Birt $5/01^{Da}$		9. Bii	thplace	(State or Foreign irginia
(+. )336			Usual Residence of Decedent							3/01/	1717	Twes	5L V.	TLATHITA
	death with the Maryland items 23a or 28a-f sho ner must be notified at	ctor	10a. State 10b. County Washin	ngton	1	Town or Loc								nside City Limits
	or 28a notifi	Dire	MD Washington Hagerstown  10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?			
	with the 23a c	Funeral Director	308 Bentley Court 21740									.S.A.	Juliu y :	
	death items ner m	F	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	. 13. V	Vas Decedent of F Yes, specify Cub	Hispanic Originan, Mexican, I	n? (Specify Puerto Rica	Yes or No-		14. Race - Ame		dian,
	after al", or xamir	d by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	No	1 ☐ Yes 2 🗓 No Specify:							hite		
7-10	hours natur lical E	lete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of But							nd of Business	industry	y		
MARY 21215-	hin 72 ne. than " e Mec	Completed	Elementary/Seconday (0-12)	College (1-4 or s	5+)	life. DC	ind of work done DNOT use retired, <b>mstress</b>	auring most o )	of working	111	۰	oui na		
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship ( Tina Sexton / Gi		er		g Address (Street Inglesi						p Code) !120	
	of Hes of Hes if item ir othe		20a. Method of Disposition  1 XBurial 2 Cremation 3	Pemoval from State		ace of Dispos	sition (Name of natory or other pla	ce)	Date		20c. Lo	ocation - City or	Town, S	State
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	Depa Impo any in		21. Signature of Funeral Service Licer	unchu	nc	22.	Name and Addre 202 Gree	ne St.	Upchu: , Cum	rch F berla	uner nd,	al Home MD 215	02 <sup>P</sup>	.A.
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	e Hos 124 hc e Fune	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  4 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										and manner stated.	
	To the within To the Comp		b. Signature and title of certifier 29c. License number 29d.								29d. Dat	Date signed (Month, Day, Year)		
5 Dedu MD D46501 Ava									1,14,	,14 , Jo12 · 1-432 - 8470				
	nes		30. Name and address of person who	completed cause of d	leath (Item:		rint) 74NS R	247 =	300015	3000	3.	01-432 1241AN	7-5	3470
	Sta	te	31. Date filed (Nd Ch. 2) (Ye 2012	32. Registra	ar's Signatu	foark.	ITAN K	ע עווע	WIN)	DUKO	ITE	IN LITTY	2	4.1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Russell Η. Bosworth Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death AGNES BALTIMORE HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 022-14-3936 90 Director 1 M 2 D F Jan. 10,1922 Rhode Island Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2X No ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 709 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S.

Armed Forces?
1 by Yes 2 \( \triangle \) No
1f Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 😾 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify White 3 Widowed 4 Divorced Specify. Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important, if item 27 is marked other the any injury or other traumatic event, the 1 once. the Communications U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell Wilson Bosworth Helen Coy Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Jones/ Daughter 1438 Westway Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State August 23, Crownsville, MD Donation 5 Other (Specify) MD Veterans Cemetery 2012 21. Signature of Fu Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia Aspiration Records, 1 Yes 2 No 3 Probably 4 Unknown Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes the Hospital or Attending Physician: Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural of Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injurv work?
1 \( \sum \text{Yes} \quad 2 \sum \text{No} \) 5 Pending Division 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Gebrewold AUGUST 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LATON AVENUE, BALTIMORE, 900 GEBRENOL

Registrar

DHMH 17 Rev 06-2011

State

AUG 23 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	ier	4a. Facility Name (if Residence			or Location of Dea	4c. County of Death Prince George's									
Funeral Director		5. Social Security N 199–14–4		6. Sex 1 □ M :	7. Ag	je (In yrs. la 88	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			g. Birl Penri	thplace (State or Foreign		
nd now at	Ļ	Usual Residence of 10a. State	Decedent 10b. County			10c City	v, Town or Lo	ention							
Marylar 28a-f sl otified	irecto	Maryland	Prince	Geor	ge's		owie	cation					10d. Inside City Limits 1 ☐ Yes 2 🏝 No		
s 23a or	Funeral Director	10e. Street and Number 4203 Enterprise Road 10f. Zip Code 20720 10g. Citizen of What USA													
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 <b>X</b> XWidowed		ed 1	as Decedent med Forces? Yes 2 X Yes, Give ear or Dates.	Ever in U.S No	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 💢 No		)	14. Race - Ame Black, White Specify: Wh				
72 hou "natu edical	Completed	(Spe	15. Decedent ecify only highes	t's Education	n npleted)		(Give i	dent's Usual Occup kind of work done	during most of wo	orking	16b. K	b. Kind of Business Industry			
ygiene. her than t, the M	Be Con	Elementary/Second 12			ollege (1-4 or	life. DO NOT use retired)						ederal Government			
d be filed Mental H arked ot rtic even	To B	17. Father's Name (i			S1omi	nski			18. Mother's Na Mary		dle, Maiden Surname) emboski				
12 shoul lith and I 27 is ma r trauma		19a. Informant's Na Linda S			*			b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4203 Enterprise Road, Bowie, Maryland 2							
of Heg of Heg if item ir othe		20a. Method of Disp	position			20b. P	lace of Dispo	sition (Name of		Date	1	ocation - City or			
it. Pag irtment irtant: njury c		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Md. Veteran Cem.  08/27/2012 Cheltenham,													
permi Depar Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Road Oxon Hill, Maryland 207													
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):													
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ecuted and -transit	al Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last													
te be ex nysician ne burial	dical E	resulting in death) Last  Due to (or as a consequence of):  d													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE:     23c. If yes, outcome of pregnancy       23b. Was decedent pregnant in the past 12 months?     23c. If yes, outcome of pregnancy       1 ☐ Yes 2 No     1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy       23d. Date of death 5 ☐ Other (specify)											ivery Day Year		
hat the ed by th detach															
een sigr	ted b	1   Yes 2   No 3   P													
r: The law r icate has b r, page 2 sh	Completed by											prior to death?	opsy findings available completion of cause of		
ysiciar s certii directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2  ER/Outpatient 3 DOA  Other:  4  Nursing Home 5 Residence 6 Other										Assiste	Living		
ling Ph		27. Manner of Doth	h 5 🗌 Pending		a. Date of inju (Month, Da	ry	28b. Time of injury	28c. Injur work	y at </td <td></td> <td colspan="4">d. Describe how injury occurred</td>		d. Describe how injury occurred				
f or Attend after death Director: /	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6  Could n determin	ot be							al Route Number,				
e Hospita 124 hours e Funeral leted filled	Medical	(Check 2	Medical Ex	aminer: On	the basis of e	xamination	and/or invest	occured at the time ligation, in my opinion	on, death occurred	at the time, date	and place.	and due to the c	ause(s) and manner stated		
To the comp	2	29b. Signature		7/	1										
		29d. Date signed  29d. Date si									20/12				
lu		ARTHUR S.	CHRODE	and	HOWE F	HYSIC	IBNS 7	Of Dies	ITA DEI	VE LINT	HICV	u MD	4090		
Stat Registra		31. Date filed (Month	AUG 22	2012	32. Registra	ar's Signati	d.	ans							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month LOUISETTA BREVARD 03:40 Medical AIIG. 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GOERGE CITATION SOUTHERN MARYLAND HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number Hours Days Director 1 □ M 2 🔀 F 579-22-3256 93 JAN. 25, 1919 VIRGINIA Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WASHINGTON DC1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 U.S.A. 4339 BOWEN ROAD, SE APT. 201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Š 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event: the Me-Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT CIVIL SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LELIA JANE JOHNSON JOSEPH ANDREW BALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7207 LANSDALE ST. DISTRICT HGTS, MD 20747 JOHN A. HARRIS (NEPHEW) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State BALL FAMILY CEMET. 09/04/2012 LANCASTER, VA ◆ ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 784 MARY BALL ROAD 21. Signature of Funeral Service Licensee BERRY O. WADDY LANCASTER, VIRGINIA 22503 23a. Part 1. Enter the disea \*\*, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Mesmon Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year P.0. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phy within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending 1 Natural 2 Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 069737 29 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANIKONTU 7503 Surratis Par Chinton Md ODKEER

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Aug 18, 2012 2:35 PM <sup>M</sup> Thomas Carroll Coulehan Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany 600 Furnace Street Cumberland If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Director** Aug 22, 1950 Country 219-74-2948 1 **X** M 2  $\square$  F 61 28a-f show 10a, State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director MD Allegany Cumberland 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 600 Furnace Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Tes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 0 disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Madge Heber Bernard Coulehan other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21502

Cumberland MD 21502 and is m 19a. Informant's Name/Relationship (Type, Print) Bernard Coulehan Health a brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 8/20/2012 Cresaptown MD Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA signature of Funeral Service Lio Insee 108 Virginia Avenue: Cumberland, MD 21502 Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year ed by the at detached for Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 NO Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

025 Kent AVR. Sto

.309 Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nellie Mae Chaney Month 0820 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 218-16-3565 91 PA Country 1 🗆 M 2 🔀 F August 29, 1920 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Allegany Frostburg 1 Yes 2 No 10e. Street and Number 207 West Mechanic Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 2 A No 1 ☐ Yes 2 🕱 No Specify. If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) ife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry E. Wolford Alice Marie Skidmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Hawkins 17611 Old Dan's Rock Rd. Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park August 21, 2012 Frostburg Maryland 21. Signature of Funeral Service Lie 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Metastatic resulting in death) Due to (or as a consequence of):

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu

Physician/

Medical

Director

Funeral

Completed by

Be

2

10a. State

Examiner

**Funeral** 

Director

28a-f show

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi inry or other traumatic event, the Medical Examiner must be notified at

Department of H Important: If ite any injury or ot once.

Physician/

Medical

Baltimore, Maryland 21215-0036

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery Month Day Year			
Completed by Pl	Part II. Other significant conditions co	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Onknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?				
	25. Was case referred to predical	00 Division (Division (Co. )	1 Yes 2 No 1 Yes 2 No			
Be	evaminer?	Hospital: Other: Other:	only one)			
2	1 Li tes 2 E No	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hon	ne 5 Residence 6 Other (Specify)			
Certificate:	27. Mannyr of Death  1 V Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	(Nonth, Day, Year) Injury work?  M 1 Yes 2 No	8d. Describe how injury occurred			
	4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical	(Check 2 L. Medical Exami	cician: To the best of my knowledge, death occurred at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at the Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner stated.			

R197475

12500 Willowbrk Rd, Cumberland, MD 21502

29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011

State

31. Date filed

29b. Signature and title of certifier

Tarka

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANITA (ACCACA ACN) 12500 Willowb

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.																
Physici edical Exam		Decedent's Name (Fire Charles Edga:	r Clark								2	Date of De Month August 2	ath Day	Yea 2	r	3. Time of Death 1852 hrs		
		4a. Facility Name (if not 32 S. West Stre	nstitution, g	ve street and n	umber)	41	. City, Tow Easton	n, or L	ocation of	Death		4c	. County o	of Death				
Funeral		5. Social Security Number	er 6. \$	Sex	7. Age (I	n yrs. last bir	thday)	If Under		If Under	_	8. Date of B	hplace (State or					
Director		578-50-8788		M 2 F		72	Yrs.	Months	Days	Hours	Min.	din. 01/16/1940 Foreign Country) Flori						
ruy.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or to										or Location 10d, Inside City							
ne Maryland or 28a-f show any fied at once.	٥.	Maryland	Talbot			Easton										1 Yes 2 No		
Maryl r 28a-1 ed at o	Director	10e. Street and Number						10f. Zip Code					10g. Citizen of What Country?					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked offer than "natural", or items 23a nr 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13 14 Yes 2 No											ican, etc.)	0-	White		can Indian, Black,		
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1121 Id be f Aental	o Be											alene Pa			- Ctata	Zin Code)		
AD 2 shou h and h and h	ř	Craig Clark (	.0. Bo	,					illiber, Ci	ty or Town	i, State,	Zip Code)						
re, rate of trace		20a. Method of Dispositio	of Dispositi		of ceme	etery,	1	Date	20c. l	Location -	City or	Town, State						
Pages Pages ment o	To Fig. 1 X Burial 2 Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify: Resurrecti								on Cemetery 08/27/2012 Clinton, MD									
Balt permit. Depart Impor injury		21 Signature of Funeral Service Licensee MO1555 22. Name and Address of Facility Lee Funeral Home. Inc.											. 007	25				
Physician	- 8	20/ 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											Approximate Interval					
/Medical Examiner		failure. List only one Immediate Cause (Final		ach line. <sub>.</sub> Subdural F	lemorrh	age										Between Onset and Death		
LAGIIIIIO		or condition resulting in o	death)	Due to (or as	a conseque	ence of):												
	ner	Sequentially list condition if any, leading to immedia	ate	Due to (or as	a conseque	ence of):						· · · · · · · · · · · · · · · · · · ·						
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38760, rtificate be ing physici as the bun	an/M	IF FEMALE: 23b. Was decedent pregn past 12 months?	ant in the	1 Live I		of pregnancy	Peta	l death	3	Ectopic p	pregnanc	у		I. Date of o Month		ay Year		
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	Physicia	1 Yes 2 No 9	Unknow		nant at time	and density		r (Specify)										
O. But the d		Part II. Other significant	conditions			t not resultin	g in the un	derlying ca	ıse giv	en in Part	t I.	23e. Did t	tobacco i	use contrib	oute to t	he cause of death?		
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ords, w requir as been s	Completed											24a. Was auto	psy	pr	rior to co	opsy findings available ompletion of cause of		
Vital Recor hysician: The law r this certificate has b I director, page 2 sh	Som											1 ✓ Yes	ormed? 2 No		eath? ✔ Ye:	s 2 No		
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of V g Phys fter thi	<u>د</u>	1 ✓ Yes 2 27. Manner of Death	No	28a. Date	of Injury		Time of Inju			at Work?	15	dome 5		ry occurre		Scene		
ion teodin eath. for: A	ation	1 Natural 5 2 ✓ Accident	Pending	A 04	Day,Year) 2012	FOL 1843	JND: 3 hrs	1	Ye	s 2 🗸 N	No P	obable fa	ıll					
Division of Vital Records, tal or Atteoding Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	27. Manner of Death 1 Natural 2 National 2 National 3 Suicide 4 Homicide 2 Could not be determined 3 Suicide 4 Homicide 2 Could not be determined 2 Specify) Multi-Family Apt. 28a. Date of Injury FOUND: 1843 hrs 1 Yes 2 No 28b. Time of Injury FOUND: 1843 hrs 1 Yes 2 No 28b. Time of Injury FOUND: 1843 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Probable fall																	
fospita 4 hours "uneral	<u>8</u>	4 Homicide determined (Specify) Multi-Family Apt. 32 S. West Street, Apt B, Easton, MD  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
o the lithin 2.	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)																	
FSFS	×	29b. Signature and title o	f certifier					29c. Li								th, Day, Year)		
J. J.		Yamale Ju	Shall,	MD				C	.C.M.	.E.			Aug	ust 22, 1	2012			
1400		30. Name and address of Pamela E. South		Assistant		Evamina	r 900 \	N. Baltir	nore :	Street,	Baltim	ore, MD 2	1223					
	ate	31. Date filed (Month)			egistrar's S	Signature	par											
Regist			~		-													

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Onza 2: 43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 011 3709 randy Wine 2009 Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 218-24-2462 Director 1 M 2 - F 84 -5-1928 Marzaland or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No randywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13709 USA 20613 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trash 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ CArrell William COTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Catherine Brand Carroll-Old 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation -25-12 21. Signature of Funeral Service Licenses Name and Address of Facility 20608 Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ξ Month Day Vear should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 M No ပ္ 1 Inpatient 2 ER/Outpatient 3 00A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.
I Director: Af 1 Yes Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2**9**b. Signature 29d. Date signed (Month, Day, Year) 2012 ss of person who completed cause of death (Item 23a) (Type, Print

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 28974 Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 17<sup>Day</sup> 2012<sup>ear</sup> 6:45A. Nancy Avey Campbell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death Prince George's Silver Spring Renaissance Gardens at Riderwood Village Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 578-42-8896 Apr. 1930 Pennsylvania Director 1 D M 2 3 82 Usual Residence of Decedent show 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sl e notified Maryland Silver Spring Montgomery 1 Yes 2X No 10f. Zip Code 20904 10e. Street and Number 10g. Citizen of What Country? United States "natural", or items 23a or Funeral 3122 Gracefield Road, CT508 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3X Widowed 4 ☐ Divorced Completed er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Department of Health and Mental Hygies Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Jacob Avey Florence Eleanor Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Shears Court Laurel, Maryland 20723 Charles E. Campbell -son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Park Lawn Mem. Park 8/20/2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bonald WesBorgwardt Funeral Home, PA Wonold 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Ovarian Cancer vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate
cause. E. ter Underlying
Cause (Disease or injury) Due to (or as a consequence of): The law requires that the death certificate be executed an and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical the bur Division of Vital Records, P.O. Box 68760 as t nse s 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 🛣 No Day Pregnant at time of death Month Year been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No death? 1 Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) 2 💢 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of after death.

Director: After t Certificate: 28d. Describe how injury occurred Natural 5 Pending the 1 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person w Eileen Gemmell,

Registrar

31. Date filed (Month, Day, Year)

AUG 22 2012

Gracefield Road Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GLADYS S. 1202 PM CAHALL August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Easton Talbox 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days March 24 Months Hours Min. Maryland 92 Director 220-01-6708 1 □ M 2 🗗 F ´1920 Yrs Usual Residence of Deceder and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Queen Anne's Centreville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2620 Price Station Rd. 21617 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married 21215-0036 White If Yes Give 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Itimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Ridgeway Nelson Lydia Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Cahall Conley (daughter) 2620 Price Station Rd. Centreville, MD. 21617 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chesterfield Cemetery 9/4/12 Centreville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Significe of Juneral Sor 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St Galena. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition DAYS Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Crutifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Drawin D 00 66441 28 2012 AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KM); Ramely 2195 WASHINGTON ST, EASTON MD 21601

State

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eleanor W. Cuthbertson 16:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Hours 214-28-6958 80 **Director** 1 M 2 X F 11-28-1931 Mary land or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Frostburg 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 "natural", or items 23a o Funeral 21532 U.S.A. filed within 72 hours after death with 11304 Parkersburg Road NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📕 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced er than "natur , the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Shirt Factory it. Page 1 and 2 should be filed withi rtment of Health and Mental Hygiens rtant: If item 27 is marked other th njury or other traumatic event, the a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Winner Elizabeth Rase Winner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11304 Parkersburg Road NW Frostburg, MD 21532 John Cuthbertson husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-30-2012 | Flintstone, MD MD State Veterans 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. Man 60 W. Main Street Frostburg, MD 21532 mas 547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph\_sician/ RENAL FAILURE ONE DAI ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate oduce. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month 4 Pregnant at time of death 9 Unknown page 2 should be detached g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Name and address of person who completed cause of death (Item/23a) (Type, Print) Glenn Street Cumberland

Registrar

32. Registrar's Sig

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	ryland /		irtment of F <i>tificate of L</i>		-		112	2007	7			
	_		Registrar  1. Decedent's Name (First, Middle, Las.	t)	··· <del>·</del>	Cer	incale or L	Jealii	2. Date of De	Reg. No. 2	112	3. Time of Death	_			
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-	Medi Examir		4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Dea			y of Death	14.5/ [.				
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	Funeral		Social Security Number     6. Se	1	(In yrs. last b	birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Birth	place (State or Foreig try)	ın			
	Director		575-50-8747 Usual Residence of Decedent	□ M 2 <b>X</b> ) F	65	Yrs.			May 4,	1947	Penn:	sylvania	- 1			
	land shov d at	호	10a. State 10b. County		10c. City, To	own or Loc	ation				1	0d. Inside City Limits	s			
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	th the 3a or the n	alD	10e. Street and Number	-			10f. Zip Code			10g. Citizen of		try?				
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21215-0036	filed within 72 hours after death with the Maryland al Hygiene. J other than "natural", or items 23a or 28a-f sho dother than "starminer must be notified at went, the Medical Examiner must be notified at	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates.			Yes, specify Cuba		rto Rican, etc.)	Yes or No- in, etc.)  14. Race - American Indian Black, White, etc.  Specify: white						
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	and 2 s Health a em 27 i ther tra		Janel Susan McPhi	llips, dau	ighter	161	.1 Meadow	Oak La:	ne, Hunt:	ingtown	MD	20639				
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □	Removal from State	ceme	e of Dispos etery, crem	sition (Name of atory or other plac	re)	Date	20c. Location	- City or To					
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Bal	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.	1	The surre of Funeral Service Lights	Telba	h	83		armony	Rausch Fu Lane, Ow	ings, M	Home, 207					
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Box	the Hospital or Attending Physician: The law requires that the death certifica hin 24 hours after death.  In 24 hours after death.  the Funeral Director. After this certificate has been signed by the attending p the Funeral Director. After this certificate has been signed by the attending p mpletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 mont s? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at t			Other (specify)	, ,		M	onth	Day Year				
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al F	ician: The certificate rector, pag		25. Was case referred to medical				26. Pla	ace of Death (Ch		2 No	1 🗌 Yes	2 14 140				
Ζij	hysici nis ce	일	T L Yes 2 2 140	lospital: 1 🔲 Inpatier	nt 2 ER/	Outpatient	3 DOA Othe	er: 4  Nursing	Home 5 Resid	dence 6 🗆 Oth	ner (Specify)					
Division of Vital Records,	ing P	ate:	27. Mann f Death  1 ► Natural 5 □ Pending	28a. Date of injury (Month, Day,		o. Time of injury	28c. Injury work	?	28d. Describe h	now injury occur	red					
Sior	ttend death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	29 o Place of Injun	/ At home	form atro		Yes 2 No	205 11' "			D				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route N City or Town, State)											Houte Number,					
	To the Hospital or Attending Physician: "Thin 24 hours after death as a feet death. To the Funeral Director. After this certifical completely filled in by the funeral director,	Medical	29a Certifier 1 Certifying Phys	ician: To the best of m	ıy knowledg	e, death o	ccurred at the time	e, date and place	, and due to the ca	ause(s) and man	ner as state	d.	$\dashv$			
	the Ho nin 24 the Fu	Mec	(Check 2 Medical Examir only one) 3 Certifying Nurs	ner: On the basis of exa e Practitioner: To the l	amination and best of my kr	d/or investi nowledge,	gation, in my opinic death occurred at t	n, death occurred he time, date and	at the time, date a place, and due to t	and place, and du the cause(s) and	ie to the cau manner as s	se(s) and manner stat tated.	ted.			
	North Con		29b. Signature and title of certifier	100			29c. License	number	2	29d. Date signe	ed (Month, I	Day, Year)				
			- Cruch Old	1,1110			WGO	7/15	1 m	MUAN	312	4201	4			
			30. Name and address of person who	propleted oause of dea	(item 23a	a) (Type, Pr	Int) /odlo de in	I san	5 2754	170	ERIC	BERG				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	117	WW/MIL	) / ////	1 CAURO	10			$\dashv$			
6.44	Registra		AUG 27 2012 2	un d.	back	and a										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day С. Doescher Medical August 2012  $10 \cdot 12$ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2300 Musgrove Road Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 032-38-6589 Days Hours Min. (Month, Day, Year) Director 1 □ M 2 🔼 F 63 Yrs. Jan. 6, 1949 NY filled within 72 hours are tall Hygiene.
ed other then "naturel", or iteme 23a or 28a-f show ed other then "naturel" or iteme 23a or 28a-f show event, the Wadical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 😾 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Musgrove Road 20904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. White ģ 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) and 2 should be file. Health and Mental H tem 27 ie merked ot 18. Mother's Name (First, Middle, Maiden Surname) Vincent L. Whitcomb Constance L. Bergquist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 sh Depertment of Health ar Importent: If Item 27 ie any injury or other trau Rex A. Doescher/Husband 2300 Musgrove Road, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20, Aug. Metropolitan Crematory: 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury Due to (or as a consequence of): attending physician and for use as the burlal-trensit Attending Physicien: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Using Birth 2 Fetal death IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day Yes 2 XNo ed by the a g [] Unknown q | | Unknown To the Hospitel or Attending Physicien: The lew requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completely filled in by the funeral director, page 2 should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ₺ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number D33293 August 20, 2012 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Frederick P. Smith, MD 5454 Wisconsin Ave., #1300, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year)

State

Registrar

AUG 21 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

AUG 21 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year David Albion Estabrook A M August 1:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 04/22/1931 Director 028-22-5959 81 Massachusetts Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 👿 No Marvland Calvert Port Republic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2925 Yoe's Corner Lane 20676 United States 11 Marital Status 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.
Armed Forces?
1 by Yes 2 □ No
If Yes, Give
Year or Dates 1952-1955 Black, White, etc. <u>م</u> 1 Never Married 2 X Married Maryland 21215-0036 e filed within 72 hours after ttal Hygiene. ed other than "natural", o 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lab Instructor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Glendon DeWitt Estabrook Nina Tongue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is Jane Yoe Estabrook / Wife 2925 Yoe's Corner Lane, Port Republic, MD 20676 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or Metropolitan Crematory 08/23/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA. 4405 Broomes Island Rd., Port Republic, M Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 27m Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Line and Live Bregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No the : 9 Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 + No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 'Within 24 hours after death.

To the Funeral Director; After this certified Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature KW jOl e of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Box 68760

P.O.

Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUG. ELLINGSWORTH 2012 JACQUELINE 4:51 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 8. Date of Birth OCT 5, 1935 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Min. Hours Country) MARYLAND Director 215-30-9173 76 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director items 23a or 28a-f s her must be notified 1 Ty Yes 2 No ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 570 BELLERIVE RD. 21409 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify Completed 3 🕅 Widowed 4 🗆 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) the HOMEMAKER HOME Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ PERCY DIGGS CORABELL ARNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH ELLINGSWORTH/SON 106 LAKE AVE., STAUNTON, VA. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-21-2012 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. CREMATORIUM, P.A. RIVERDALE, MD. 20737 Signature of Euneral Service Licerses M00091 RIVERDALE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events d for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 Tes 2 No 3 Probably Mullinknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No Investigation the Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by Hospital

> State Registrar

Medical

29a. Certifier

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Annero hi

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28982 Certificate of Death Reg. No. 2 2. Date of Death Month Physician/ 5:10 A M August Holmes Eugene Fowler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Calvert Asbury Solomons 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Hours **Director** 217-32-3572 1**X**XM 2 □ F 76 Dec. 27, 1935 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No |Maryland| Calvert Lusby 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 13680 Store Road 20657 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 1 Never Married 2X Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th. Business Owner Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Holmes L. Fowler Cecilia Thrice Jage 1 and 2 shr Jepartment of Health and Important: If item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m 19a. Informant's Name/Relationship (Type, Print) 9120 Penns Hill Road, Laplata, Maryland 20646 Jennifer Ross/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Memorial Grdn's Aug. 24. 2012 Waldorf, MD. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee BO35 Old Washington Rd. Waldorf, MD. 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DISEASE Immediate Cause (Final ARTERY CORONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical death certificate be P.O. Box 68760 as the k IF FEMALE use a yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellile 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen Disease Vascula 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an a this certificate has Congestive perform Hearl 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ Other: ursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide Accident within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 [] 3 [] Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATmuna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 HOSP RD. PRINCE FREDERICK Sule 300 MUNSAI-MD AUG 2 4 2012 State

DHMH 17 Rev 06-2011

Registrar

			State of Maryland / Dep	partment of Health and Nertificate of Death		2012 20003				
			Registrar  1. Decedent's Name (First, Middle, Last)	runcate or Death	Reg. N 2. Date of Death	3. Time of Death				
	Physicia Medic		John E. Fish		August 1	9 20 <sup>4</sup> 72 12:15 a M				
- /	Examin	ier	4a. Facility Name (if not institution, give street and number)  138 Round Bay Road	4b. City, Town, or Location of Death Severna Park	4	c. County of Death Anne Arundel				
H	Funeral Director		5. Social Security Number 216–16–8304 6. Sex 1 M 2 F 88 1 M 2 F 88 1 Sex 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Maryland				
	yland f show	ş	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits				
	ne Mar or 28a- notifi	Dire	MD Anne Arundel Severa	na Park	10- 6	1 ☐ Yes 2 🛣 No  Citizen of What Country?				
	s 23a c	Funeral Director	138 Round Bay Road	21146	log. c	USA				
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☒ Yes 2 □ No  If Yes, Give  Year or Dates. ₩₩ II	Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
15-0	72 hou 1 "natu ledical	nplet	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work	ing 16b.	Kind of Business/Industry				
212	within giene. er than		Elementary/Secondary (0-12) College (1-4 or 5+)	Vice President		Banking				
Maryland 21215-0036	lld be filed Mental Hy iarked oth atic event	To Be	17. Father's Name (First, Middle, Last)  Earl Fish	18. Mother's Nam <b>Thelma</b>	e (First, Middle, Maider Ostendorf	n Surname)				
, Mar	nd 2 shou lealth and m <b>27 is</b> m	97	Patricia Fish/Wife 138	ing Address (Street and Number or Rura B Round Bay Road	Severna I	or Town, State, Zip Code) Park, MD 21146				
Baltimore,	. Page 1 a ment of H tant: If ite jury or oth		- Band Las oromation o Enternoval notation	ematory or other place) Auc	i. 23	Location - City or Town, State				
Ball	permit Depart Impor any in		21 gnature of Fu and Service vicens/e	2. Name and Address of Facility arranco & Sons, P.	A. Severn	a Park Funeral Home a Park, MD 21146				
H	23 Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or leart failure. List only one cause on each line.									
-	Medical	/	result ain death)	_uncl/		Interval Between Onset and Death				
	Examiner		Due to (or as a consequence of):							
	ed sit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe Univ							
	execute an and rial-trar	Еха	that initiated events resulting in death) Last  C. Due to (or as a consequence of):							
9	ate be executed ohysician and the burial-transit	dica	d							
Box 687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- 300		23d. Date of delivery				
). Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year				
, P.O.	es that signed I be dei	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?				
Records,	v requi	Completed			24a. Was an	24b. Were autopsy findings available				
Rec	The lav ate has page 2	Comp			autopsy performed 1 Yes 2 N	prior to completion of cause of death?				
Ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 U Yes 2 No Hospital:   I postingt 3 U FB/Outsetic	26. Place of Death (Check						
of V	ng Physter this neral d	te: To	27. Manner of Death 28a. Date of injury 28b. Time of	ont 3 ☐ DOA ☐ 4 ☐ Nursing Ho  st 28c. Injury at	me 5 Residence 28d. Describe how inju	6 Other (Specify)  ry occurred				
sion	al or Attending P s after death. Il Director: After ti ed in by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No						
Division of Vital	al or A s after al Direct ed in by		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)				
_	Hospi 24 hour Funer etely fill	Medical	29a. Certifier (Check Medical Exemples: On the basis of examination and/or investigation).	stigation, in my opinion, death occurred at	the time, date and place	e, and due to the cause(s) and manner stated.				
	To the within To the compl	Σ	only one) 3 Certifing Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	20c License number	29d. Da	ate signed (Month, Day, Year)				
			* (X)	065272		20112				
7)	410+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Ckuy Sud	( 210 A	100 2140) MO 2140)				
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature AUG 2 3 2012							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Py 2012 8:20 P M Nyla Freeman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 12 A Bens Drive Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, 1 Days Maryland 216-82-9743 **Director** 1963 49 Yrs une Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera A Bens Drive 21403 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 X Never Married 2 ☐ Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 ! (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Mixologist Peerless Rens Club Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည 2 Jordan Freeman Cynthia Raikes t. Page 1 and 2 should by treet of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derethia Calhoun(Daughter) 702 F Newtown Dr. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 8-23-12 Annapolis, Md. 21. Signature of Funeral Service Licenses 24 Manne a Broaders Son Facility Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) (or as onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine page 2 should be detached for use as the burlal-transit The law requires that the death certificate be executed Cause (Lisease or i that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Othe ificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director. of Vital 25. Was case ref To Be 6. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DO/ 5 Residence 6 Other (Specify) 27. Manner of De 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: Joing best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie (Check 29b. Signature and title of certifier 29d, Date 30. 31. Date filed (Month, Day, Year) State AUG 2 3 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ears 1141151 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Balhimore CITY OF BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In vis. last birthday) Birthplace (State or Foreign Country) Days Director 214-71-6139 1 X M 2 D F 7 10/21/2004 BALTIMORE, MD 28a-f shov 10a. State the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD WT COMT CO SALISBURY ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Items 23a 411-E WOODVIEW SQUARE 21804 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or 2 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 to 19 Health and Mental Hygiene.
If item 27 is marked other than "roother traumatic event, the Median College (1-4 or 5+) -0-Elementary/Secondary (0-12) STUDENT ELEMENTARY SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JEFFREY VALLIANT FEARS JILL ANN FANCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau JEFFREY FEARS/FATHER 411-E WOODVIEW SQUARE SALISBURY, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 08/22/2012 OXFORD CEMETERY OXFORD, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ZENAMOWS CONTROL FOR NEW NAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 JOHN R MERCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit PINNOX - Gasta Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 \ Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) *UAT* 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EGBUTA CHINYERE 1800 Ballmore ans 31. Date filed (Month, Day, Year) AUG 2. 0 20 32. Regis far's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ AUGUST 1 CHARLES RICHARD FAGAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 28573 NINTH DRIVE EASTON TALBOT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Days Hours Min Months 78 110-20-9679 Yrs Director Usual Residence of Decedent 28a-f shov aţ 10a. State 10b County 10c. City, Town or Location Director must be notified MD TALBOT EASTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 28573 NINTH DRIVE 21601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event. the Medical Once. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TV PRODUCER PRODUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES F. FAGAN FLORENCE MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH A. FAGAN, DAUGHTER 6343 PERSHING AVENUE, ST. LOUIS, MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION | 8/2/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN
200 SOUTH HARRISON 21. Signature of Funeral Service Licensee & NEWNAM FUNERAL STREET. EASTON, MD MERCERON JOHN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Msema Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mohin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arten Division of Vital Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 V death? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how Injury occurred Hospital or Attending Natural 5 Pending s after death. 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29d. Date signed (Month, Day, Year) 08-02-2012

1:45

Country)
NEW YORK

WHITE

Approximate Interval Between Onset and Death

cars

Year

10d. Inside City Limits

1 X Yes 2 No

P M

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mont

Chwood br

Easter and 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Grow Camilla Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Funeral 9. Birthplace (State or Foreign Jan 3, 1979 Director 529-77-0632 1 □ M 2 💢 F 33 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** WV Mineral Fort Ashby 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26719 15003 Hilltop Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 No Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗡 No Specify: 3 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shanna Parker Steven Charles Grow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15003 Hilltop Drive Fort Ashby WV 26719 Steven Grow father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hooper City Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 8/29/2012 UT Hooper 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Icensee 22. Name and Address of Facility all Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, ician Medical Congental heart disease disease or condition resulting in death) ears Due to (or s a consequence of): Examiner Pulmonas Decondor few years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the attent detached for t 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2nd stage Renal disease Hepatic 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 😓 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Hospital P 1 DOA Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred iniury 5 Pending Accident
Suicide Investigation after death Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Hma Strall 1246346 who completed cause of death (Item 23a) (Type, Print) . 204 Cumberland, NID 21502

DHMH 17 Rev 06-2011

State

Registrar

32. Registrar's Signature

2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28988 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month/17/2012 Year 12:35 JACOB NATHANIEL GADSON, JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgamery Olney MedStar Montgomery Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours 579-50-4041 Director 1 XM 2 🗆 F 11/25/1938 NC 73 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or "natural", or items 23a o edical Examiner must be Funeral USA 20905 17 Locustwood Court within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc δ 1 Never Married 2 Married XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 1956-1958 Year or Date Black Completed 3 Widowed 4 Divorced er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Computer Technology Ith and Mental Hygien 27 is marked other the traumatic event, the Sales Representative 4vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Gadson Jacob N. Gadson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 Locustwood Ct., Silver Spring, MD 20905 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Wanda Gadson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8/22/2012 | Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licers 22. Name and Address of Facility Snowden Funeral Home Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Interval Between Therosclerot.c Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No or Attending Physician: of Vital 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, npletely filled in by 4 Homicide determined within 24 hours a To the Funeral C To the Hospital Medical 29a. Certifier Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only of Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Day, Yea.

		For State Registrar		laryland / Depa	ndelible Ink. Ensur artment of Health and tificate of Death	d Mental Hyg	giene	2008
Physicia	m/	Decedent's Name (First, Middle	,			2. Date of Dea		3. Time of Death
Medi	al	4a. Facility Name (if not institution,		d Goldstei		August		3:55 A M
Examir	ier	17317 Germanto			4b. City, Town, or Location of De Germantown	eath	4c. County of Death Montgome	ry
Funeral Director		5. Social Security Number 579–38–7891	6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours V	Hrs. 8. Date of Birth lin. (Month, Day		place (State or Foreign try)
		Usual Residence of Decedent  10a. State  10b. County	VI W Z I F	80 Yrs.		Jan. 29	), 1932 Wash	
farylan 3a-f sh ified a	ecto		gomery	10c. City, Town or Lo				0d. Inside City Limits  1  Yes 2 No
h the M Sa or 23 be not	Funeral Director	10e. Street and Number		-	10f. Zip Code	T	10g. Citizen of What Cour United Sta	ntry?
ems 23	uner	17317 Germantov	WN KOad	Ever in U.S. 13. V	20874 Vas Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Americ	
after de	by	1 Never Married 2 X Marr	Armed Forces?	No I	Yes, specify Cuban, Mexican, Pu  Yes 2 X No Specify:	erto Rican, etc.)	Black, White,	etc.
hours a natural lical Ex	leted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		rent's Usual Occupation			
hin 72 ne. than "r ie Med	Completed	(Specify only higher	St grade completed) College (1-4 or 5	(Give I	kind of work done during most of vo DNOT use retired) Executive Offi		Country Cas Furniture C	
iled wil Il Hygie I other vent, th	Be	17. Father's Name (First, Middle, La		Cirrer		Name (First, Middle, I		
uld be f Menta narked natic ev	은	Morris Gold			Ros	e Levin		<u> </u>
12 shoutth and 27 is n		19a. Informant's Name/Relationsh Bobbie Goldstei	<sub>ip (Type, Print)</sub> n, Wife	<b>I</b>	g Address (Street and Number or Germantown Roa			<sup>Code)</sup> 8 <b>74</b>
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3  Removal from State	20b. Place of Dispos	sition (Name of	21/12	20c. Location - City or To	
nit. Pag artment ortant: injury o		4 Donation 5 Other (S		Garden of	<u>Remembrance Mé</u>	morial Par		rg, MD
Deperment of the perment of the permeter of the pe		21. St. or sineral Savica	nsee J		refrinskysHebmew 4 Carroll St.,			0012
		23a. Part Enter the disease, or shock, or heart failure. List or	complications that caused	the death. Do not ente				Approximate Interval Between
Physician Medical		Immediate Cause (Final disease or condition resulting in death)		te Cancer			1	Onset and Death  6 Years
Examiner	Ļ	Sequentially list conditions,	b.	a consequence or,				
cuted	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				
exe an a rial-	ш	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):		<u> </u>		
ate be physici	edica		d			<del></del> -		
requires that the death certificate be execut been signed by the attending physician and should be detached for use as the burial-train	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy		23d. Date of delive	ery
t the death by the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a		Other (specify)		Month	Day Year
that the	by Ph	Part II. Other significant condition	ns contributing to death b	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did tob	pacco use contribute to th	e cause of death?
v requires that to been signed be should be detailed	ted k					_ 1 🗆 Ye	es 2 <b>X</b> □No 3□Prob	ably 4 🗆 Unknown
e law re has be ge 2 sh	Completed					24a. Was ar autops perforr	sy prior to cor	sy findings available npletion of cause of
Physician: The law r this certificate has larel director, page 2 s	as I	25. Was case referred to medical			26. Place of Death (Ci	1 Yes		2 🗆 No
hysici this cer al direc	To B	examiner?		ent 2 ER/Outpatient	Other:		ence 6 Other (Specify)	
	Certificate:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident Investige		ry 28b. Time of injury	28c. Injury at work?  M 1  Yes 2  No	28d. Describe ho	w injury occurred	
nding I tth. : After e funer	¥= I	3 Suicide 6 Could n	ot be	un. At harma farma atua		28f. Location /Str	reet and Number or Rural	
or Attending I fter death. irector: After n by the funer	ET.	4 Homicide determin			et, factory, office		State)	Route Number,
or Attending after death. Director: After in by the fune		0	ned 28e. Place of Inju- building, etc	(Specify)		City or Town		
To the Hospital or Attending Phys within 24 hours affer death.  To the Euneral Director, Affer this completely filled in by the funeral di	Medical Certi	29a. Certifier 1 X Certifying I (Check 2 Medical Ex	phed 286. Place of Injubuilding, etc.  Physician: To the best of examiner: On the basis of examiner.	my knowledge, death oxamination and/or investi	courred at the time, date and place gation, in my opinion, death occurred death occurred at the time, date and	e, and due to the cau	se(s) and manner as state	d.

Registrar DHMH 17 Rev 06-2011

State

Joseph M. Haggerty, M.D., 9707 Medical Center Dr., #300, Rockville, MD 20850
31. Date filed (Month, Day, Year)
AUG 21 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			for State of Maryla				, ,	0.0.1	0 00000		
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eath		3	2 28990		
н	Physicia		Gloria A. Gomez				Date of Death     Month		3. Time of Death		
- 3e	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	August				
ange a	,		Tate Chesapeake Hospice House	9	Linthi			rundel			
	Funeral		165 24 2022	s. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9			
	Director		Usual Residence of Decedent	Yrs.							
	and show	ģ	10a. State 10b. County 10c.	City, Town or Lo					10d. Inside City Limits		
	Maryl 28a-f otifie	Director	MD Anne Arundel A	Annapoli	.S				1 ☐ Yes 2 🔀 No		
	h the	a D	10e. Street and Number		10f. Zip Code		1		at Country?		
	ms 2%	Funeral	1229 Destiny Circle	L.s.	21409			USA			
(0	er des or ite niner	by Fu	11. Marital Status  1 □ Never Married 2 🌠 Married  12. Was Decedent Ever in I Armed Forces?  1 □ Yes 2 🛣 No		Vas Decedent of Hisp Yes, specify Cuban,						
8	ırs aft ural", IExar	ed k	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 💢 No	Specify:		Specify:	White		
5-(	72 hou "nati edica	plet	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupati ind of work done dur		ing	16b. Kind of Busin	ess/Industry		
21215-0036	ithin and the series.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		NOT use retired) nemaker			Reg. No. 2 0 1 2 2 8 9 9 0  Ite of Death Day Year Qust 21, 2012 3:45 A M  4c. County of Death Anne Arundel  te of Birth Onth, Day, Year)  V. 02,1931 9. Birthplace (State or Foreign Country)  V. 02,1931 10. Inside City Limits 1 Yes 2 No  10g. Citizen of What Country?  USA 10d. Inside City Limits 1 Yes 2 No  10g. Citizen of What Country?  USA 16b. Kind of Business/Industry  Home Middle, Maiden Surname)  Moby Number, City or Town, State, Zip Code)  apolis, MD 21409  7, 20c. Location - City or Town, State  Crownsville, MD  Severna Park Funeral Home Severna Park, MD 21146  atory arrest, Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No  1 Yes 2 No 1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  23d. Date of delivery House of death?  1 Yes 2 No 1 Yes 2 No  1 Yes 2 N			
102	iled w other vent, i	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M				
Maryland	d be f Menta arked atic ev	은	Lloyd Spatz				Rimby				
Mar	shoul and is m	1	19a. Informant's Name/Relationship (Type, Print)								
e, P	and 2 Health em 2; ther t		Raymond Gomez/ Husband  20a. Method of Disposition 20b	. Place of Dispos		-					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burlal 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	natory or other place)	: Lugue	st 27,		-		
ati	mit. Poartme	1	21. Signature of Funeral Service Licensee		ns Cemete  Name and Address		2012				
Ö	permi Depar Impo any ir once.		1/25	Sons, P. Hwy,	A. Sever Sever	na Park na Park,	MD 21146				
			23a. Part 1. Enter the disease or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ente	r the mode of dying,	such as cardiac o	r respiratory arres	t,			
ant of the last	Medical	e i	Immediate Cause (Final disease or condition resulting in death)	AS7471	+ ARFAST	7 CANCE	N		Onset and Death		
	Examiner		Due to (or as a conse	quence of):							
12 - 1		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of):					1		
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
	ate be executed physician and the burial-transit	alE	resulting in death) Last Due to (or as a conse	quence of):							
760	death certificate be executed ne attending physician and led for use as the burial-transi	edical	d								
687	certifi inding use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg					23d. Date of	f delivery		
Box	requires that the death certifical been signed by the attending p should be detached for use as	by Physician/Me	in the past 12 months?  1		Ectopic pregnancy Other (specify)	-			,		
P.O.	at the	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not n	sculting in the ur	aderlying cause given	in Part I	00 Pittel				
ω, σ.	res tha signed	d by	vaca. Other signment conditions continuing to death but not h	esciting in the di	idenying cause given	illi Faiti.					
ğ	requi been shoul	lete			·		1				
ec	sician: The law scortificate has the director, page 2 s	Completed					autopsy _ perform	ed? prior	to completion of cause of h?		
e H	an: Th	Be C	25. Was case referred to medical		26. Place	e of Death (Check		No 1 □	Yes 2 No		
Ž	hysici nis cei il direc	To E	examiner?  1  Yes 2 No Hospital:  1  Inpatient 2	☐ ER/Outpatient	Othor			ce 6 Other (S	pecify) HOSDICE		
י סל	ling P	ate:	27. Mann of Death  1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		28d. Describe how	injury occurred	HOUSE		
Sior	Attend death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Description de	nome farm etre		s 2 🗆 No	205 1 (01				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)											
	the lithin 2:	Me	only one) 2 Critifying Nurse Practitioner: To the best of	my knowledge,	death occurred at the	time, date and place	ce, and due to the	cause(s) and mann	er as stated.		
	<b>5</b> ≥ <b>5</b> 0		Ed. Signature and moderning		Z9C. License nu	64952	29	d. Date signed (Mo	onth, Day, Year)		
,			30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Pr	int)	-		٥٥١٤١١١٥	7		
U	48		DR. RAVIN GARL 2003,	Medica	1 Parkw	ary Su	ite 210 ,	Annapol	15, MD 21401		
	Stat Registra	e Ir	31. Date filed (Month, Day, Year)  AUG 2 3 2012  32. Registrar's Sign	ature .	and						

			For State Registrar	State of Ma		epartment c Certificate c		and Mental Hy	giene 2 (	112	28991
	Physicia	ın/	1. Decedent's Name (First, Middle, La					2. Date of De	eath	Year	3. Time of Death
	Medic Examir	cal	4a. Facility Name (if not institution, give	e street and number)		4h City Tow	n, or Location o	8/	18/2012 4c. County		5:20 P M
-	LAGITIII		631 ADMIRAL DRIVE		2		NAPOLIS			ARUNI	DEL
	Funeral Director		5. Social Security Number 6. S 177–28–9891 1	ex 7. Age	(In yrs. last birth	Months Da		24 Hrs. 8. Date of Bi Min. (Month, Da		9. Birthp Count	place (State or Foreign try)
			Usual Residence of Decedent	LI WI Z LAF	76	rs.		5/2/19	36		SYLVANIA
	aryland a-f she fied af	Director	10a. State 10b. County	UNID TIT	10c. City, Town					11	0d. Inside City Limits  1  Yes 2 No
	the Ma or 28 oe noti		MARYLAND ANNE AR	UNDEL	ANNAPOL	10f. Zip Cod	e		10g. Citizen of	What Coun	
	th with ns 23a must t	Funeral	631 ADMIRAL DRIVE			21401			UNITED	STATI	ES
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 XN If Yes, Give Year or Dates.	er in U.S.	13. Was Decedent of If Yes, specify C	uban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Rac Blac Specify.	an Indian, etc. <b>FE</b>	
15-0	72 hour matu edical	Completed	15. Decedent's E (Specify only highest gr	ducation		Decedent's Usual Oc Give kind of work do		of working	16b. Kind of B		
2121	vithin 7 jiene. er than the M		Elementary/Secondary (0-12)	College (1-4 or 5+		B.C	OKKEI	KKEEPING			
nd	be filed vental Hygrked otheric event,	To Be	17. Father's Name (First, Middle, Last)			OK KEEPER	18. Mothe	er's Name (First, Middle,			21 1110
Maryland 21215-0036	should be and Men is marke aumatic	1	SAMUEL STURGES  19a. Informant's Name/Relationship (7)	ima Print				ABETH WEBER			
e, Ma	and 2 should be fli Health and Mental em 27 is marked i ther traumatic ev		RICHARD GINS JR./		611	SWEET BR		r or Rural Route Numbe JRT, SEVERNA			
Baltimore,	Page ment c ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	CHESTER CENTER	Disposition (Name of crematory or other AKE CREMA	TION 8	Date 8/25/2012	20c. Location -	*	
Balt	permit. Departr Importa any inju		21. Signature of Euneral Service Licens			22. Name and Ad HELFENBEI B14 BESTG	dress of Facility	LASTING TR VNAM CREMAT AD, ANNAPOL	IBUTES I	NERAI 1401	LOWS CARE
i			23a. Part 1. Enter the disease, or comshock, or heart failure. List only o	plications that caused t ne cause on each line.	he death. Do no						Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lung Due to (or as a	cance	F					Onset and Death
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09/	certificate be executed inding physician and use as the burial-transit	edical		d							
189	certifica nding p use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				204 D.4		_
). Box	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at t 9 Unknown		3 ☐ Ectopic pregn 5 ☐ Other (specify,			Moi Moi	e of deliver	ry Day Year
s, P.O.	signed be de	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause	given in Part I.				e cause of death?
org	v requi	Completed		· · · ·				24a. Was		-	sy findings available
Yec Y	The law ate has page 2	Jon J						— autor	rmed?	rior to com leath?	pletion of cause of
Ea	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				n (Check only one)	2231101		
OT <b>&lt;</b>	g Physer this er this eral di	e: To	27. Manner of Death	1 Inpatien 28a. Date of injury	28b. Tin	ne of 28c. In			dence 6 Othe		-
00	tending leath. or: Aftu the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		<i>Year)</i> inju	ıry w	ork? □ Yes 2 □ I				
Division of Vital Records,	tal or Atres after o		4 Homicide determined	28e. Place of Injury building, etc. (		, street, factory, offic	е	28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural F	Route Number,
	the Hospi hin 24 hou the Funer npletely fil	Medical	only one) B Certifying Nurs	<b>ner:</b> Un the basis of exa	mination and/or i	ivestigation, in my on	inion death occ	place, and due to the ca curred at the time, date a e and place, and due to t	nd place and due	to the cause	one) and manner etated
	co o sit		29b. Signature and trile of certifie	9			SZ7Z		29d. Date signed	(Month, Da	ay, Year)
	25		JASON LAKSE		th (Item 23a) (Ty	pe, Print) Plan	y 50.	Je 210 A	100.60)	M	121401
	Stat Registra	e r	31. Date filed (Month, Day, Year) AUG 22 201	2 32 Registrar's		backs			•		

State of Maryland / Department of Health and Mental Hygiene 28992 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ Medical 20 Ir. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12822 Meadow resaptown If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Hours Feb 20, 1949 Country) Director 219-52-0297 1 **X** M 2 □ F 63 aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f MD Allegany Cresaptown 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n Completed by Funeral 23a 21502 USA 12822 Meadow Ave ıral", or items ! 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 
Widowed 4 Divorced white traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Roadway Corporation truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Audrey P. Ayers Walter R. Hite, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Cresantown MD 21502 19a. Informant's Name/Relationship (Type, Print) Department of Health al Important: If item 27 is any injury or other trau Martha Hite wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/24/2012 MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Address of Facility at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MORTE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician the driving the burial To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death been signed by the s should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner'i Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 D Other (Specify 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work 5 Pending 1 🗌 Yes 2 No Investigation □ Accident Suicide Could not be 3 Suiciae
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a Tom Bostaph, of death (Item 23a) (Type, Print) 30. Name and 600 31. Date filed (M State Registrar

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea	ase Type or State o			d / Depa	artmen	t of F	lealth and			_	ible.	
Physicia		1. Decedent's Name Velma	e (First, Middle	e, Last) Pearl				<i>tificate</i> inson		Death	2. Date of D Month Augus		lay 20	) + 2 1 <sup>Year</sup>	3. Firme of Death 9:30 A M
Medic Examin				n, give street and nur ch Nursing		Reha	.b	4b. City,	Town, or Cumb	Location of Dea Derland				of Death Legan	
Funeral Director		5. Social Security No. 216–22–74		6. Sex 1 ☐ M 2 🄀 F	7. Ag	e (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		sirth Day, Year) /192	7	9. Birthp Count Mar	olace (State or Foreign try) yland
tryland a-f show ied at	ctor	Usual Residence of 10a. State MD	10b. County	Allegany		10c. City	y, Town or Lo	mberl	and					1	0d. Inside City Limits 1 X Yes 2 □ No
with the Ma 23a or 28a sst be noti	Funeral Director	10e. Street and Nun 532 For	nber					10f. Zip			10g. C		What Coun		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1  Never Marri 3  Widowed		If Voc Cir	rces? 2 X /e	Ever in U.S	1	f Yes, spec	ify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	D-		e - Americ k, White, e	etc.
vithin 72 houn jiene. er than "natur the Medical.	Completed	(Spe	cify only high	ent's Education est grade completed College (1	)	5+)	life. D	dent's Usua kind of wor ONOT use omemal	k done c retired)	ation during most of wo	nrking	16b. Kind of Business Home			
d be filed v Mental Hyg arked othe	To Be	17. Father's Name (i John	First, Middle,	<sup>Last)</sup> Edgar		Ber	nett			18. Mother's Na Cote	me (First, Middle L1e	e, Maider	Surname Bur	) khart	,
nd 2 should saith and N n 27 is me ier trauma		19a. Informant's Na E. Wayne	ame/Relations e Hank:	inson / Hi	usb	and	19b. Mailir 532	g Address Fort	(Street a	and Number or R nue, Cur	ural Route Numb 1berland	ber, City o	or Town, S 2 1	tate, Zip C 502	code)
Page 1 al Iment of H tant: If itel jury or oth		20a. Method of Disp 1 🖔 Burial 2 4 🗆 Donation	☐ Cremation	3 ☐ Removal from Specify)	State	20b. P MD		matory or o m @ R	ther plac OCKy	<sup>e)</sup> Gap 08		2 1	Flint		e, MD
permit Depart Impor any in		21. Signature of Fur	100	1dans			4	04 De	catu	r Stree	t, Cumbe	erla			ome, P.A. 1502
Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or condition resulting in death)	rt failure. List Final	r complications that only one cause on each only one cause on each only one to	ach line	е.	SCLE			g, such as cardia			-52		Approximate Interval Between Onset and Death
G F G	dical Examiner	Sequentially list co If any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmedlate rlying iinjury s	с		a consequ									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☑ No		Birth gnant a		al death 3	Ectopic p		Эy		-	23d. Dai Mo	te of delive	ery Day Year
uires that the signed by all do detact	ρ	Part II. Other signif	icant conditi	ons contributing to o	death b	out not res	sulting in the u	nderlying o	ause giv	ven in Part I.			/		e cause of death?
: The law req cate has bee ; page 2 sho	Completed										per	s an opsy formed? s 2 1	_ E		osy findings available inpletion of cause of 2  No
/sician s certif directo	To Be	25. Was case referre examiner?  1 \sum Yes 2	_/	Hospital:	Innati	ient 2	ER/Outpatier	nt 3 □ D0	Oth	ace of Death (Ch	eck only one)  Home 5 $\square$ Res	sidence	6 □ Othe	er (Specify)	
ath. r: After thi	Certificate: 1	27. Manner of Death 1 Natural 2 Accident	5 Pendi	ng 28a. Date (Moning and Indiana)	of inju	- A	28b. Time of injury		8c. Injun work	/ at	28d. Describe				
ital or Atteurs after de ral Directo		3	6 ☐ Could detern	ained 28e. Place		ury - At ho c. <i>(Specify</i>	ome, farm, stre	et, factory	, office			(Street a		er or Rural	Route Number,
n 24 hou n 24 hou ie Funei oleted fil	Medical	(Check 2	Medical I	g Physician: To the b Examiner: On the ba g Nurse Practioner:	sis of e	examination	n and/or invest	tigation, in I	ny opinio	on, death occurred	at the time, date	and plac	e, and due	e to the cau	ise(s) and manner stated.
To the within		29b. Signature and	title of certifie	and To	15	zue	a Ar			number 14865			_	(Month, E	
nes		Robust	iano d					rint)		reet, Cu				1502	,
Stat Registra	e	31. Date filed (Mont	2012	Denwa	Registr	ar's Signat	parks	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Hamilton Month 22 Day Eliza Mae August 1825 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Allegany Allegany Health Nursing & Rehab Ctr Cumberland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/02/1920 g. Birthplace (State or Foreign Country) Maryland **Funeral** Days 1 - M 2 7 F Director 214-12-3977 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cresaptown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 13305 McKenzie Tower Road, SW USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is \$ 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give 1 Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Faulkner Carl Melvin Lowerv Bessie Viola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13305 McKenzie Tower Rd, SW, Cresaptown, MD 21502 Sharon F. Hamilton / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date vet Cem @ Rocky Gap 08/27/2012 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) any injury or MD Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service 404 Decatur Street, Cumberland, MD 23a. Part 1. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition onmore Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death Day Year as been signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed certificate Yes 2 No Hospital or Attending Physician: 1 24 hours after death. 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 🗌 Yes 2 No 3 Sulcide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RP 30. Name and address of person who completed cause of death (Item 23a) (Type Robustiano J. Barrera, M.D., 200 Glenn Street, Cumberland, MD 0 21502 URS 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Billie Ha11 Bowman 23 August 5:00 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Burnett - Calvert Hospice House Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year, 9. Birthplace (State or Foreign 1 M 2 X F 86 West Virginia 236-22-1961 1925 Nov. Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Calvert Marvland Dunkirk 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 2950 Cedarwood Lane 20754 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2xxxNo Specify 3 

✓ Widowed 4 

☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Senate Congressional Staffer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bowman Pansy Dye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hall - Son 2950 Cedarwood Lane, Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 24, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Lee Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD Gold 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. -infiltrating 10 William ownel Interval Between Onset and Death Immediate Cause (Final Breast Lavker disease or condition Carcinguna resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of):

Ph<sub>s</sub>ii<sub>n</sub> Medical **Examiner** 

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

**Funeral** 

Director

28a-f

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23a (

items

"natural", or iter edical Examiner

and Mental Hygiene. Is marked other than "natur raumatic event, the Medical I

of Health and Menta item 27 is marked other traumatic e

Department of H Important; If ite any injury or ot

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be

burial-transi and attending physician I for use as the buria detached 1 the s been signed by the should be detach has within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Certificate: Medical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: 10 State

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🔀 No

9 Unknown

25. Was case referred to medical

29b. Signature and title of certifier

AUG 24 2012

2 No

5  $\square$  Pending

Investigation 6 Could not be

determined

examiner?

27 Manner of Death

1 🔀 Natural

4 Homicide

29a. Certifier

(Check

Accident Suicide

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

32. Registrar's Signature

a 🗌 Unknown

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Day

Year

performe 2 🗆 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?

Hospice Horne 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

20736

MD.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lillian Month Howard Day Year 6:55 P.M Medical <u>August</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery . Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 579-44-6432 Hours Director 1 □ M 2 😿 F 87 Dec. 31,1924 North Carolina Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location the Maryland must be notified at Director 10d. Inside City Limits MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 23a 3140 Gracefield Road 20904 items 2 United States permit. Page 1 and 2 should be filed within 72 hours after death a pepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3X Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Program Management Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stacy Dobson Argie Frances Dobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances J. Dobson/Sister 4410 Oglethorpe Street, Hyattsville, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of August 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 16 Geo. Wash. University Donation 5 Other (Specify) Washington, D.C. 2012 Medical Center re of Fundral Service Licensee Smature 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 Sch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Perforated Duodenal Ulcer Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): iding physician Physician/Medical ivision of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month signed by the at d be detached f Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ New onset Atrial Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Acute Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performe death? certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ပ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after usea...

To the Funeral Director. After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c, License number D44156 who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Alexion Mb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERRICK ETER 0304 7012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min Director 023-28-4064 1 ÅM 2 □ F 74 4/15/1938 Massachusetts 28a-f show Pege 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If Item 27 is marked other than "natural", or Items 23e or 28e-f sho th and Mental Hyglene. 27 is marked other than "natural", or items 23e or 28a-f shor traumatic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 931 Edgewood Road Apt. 206 12. Was Decedent Ever in U.S.

Armed Forces? 1960−

1 X Yes 2 □ No 1966 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Divorced 4 Divorced 1966 Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Α. Herrick Esther В. Frost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Herrick/Wife 931 Edgewood Road Apt. 206, Annapolis, MD 21403 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of F important: If ite eny injury or ot once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Kalas Crematory 8/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland Signature of Funeral Service L 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ RUKE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). y physicien end as the burial-transit Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physiclan/Medical Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Pregnant at time of death tor: After this certificate has been signed by the tithe funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. To the Hoapital or A within 24 hours after To the Funeral Direc completely filled in by City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cettifie ause of death (Item 23a) (Type State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maurice J. Harmon, Jr. 2012 August 2:21 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 107 Wineland Way Stevensville Queen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) District **Funeral** 7. Age (In yrs. last birthday) Hours 577-30-1536 Director 85 1 XM 2 🗆 F Jan. 07,1927 of Columbia Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director Stevensville Oueen Anne's MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21666 USA 107 Wineland Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify. 3 XWidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Safety Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pauline Waters Maurice J. Harmon, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
128 Creekside Commons Court Stevensville, MD 21666 Julie Harmon / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State st 21, 2012 August Baltimore, MD Metro Crematory, INC. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Direct 495 Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park, MD 21146 r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Du to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 5 Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 🗆 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier vorus Nulsk 10+1 who completed cause of death (Item 23a) (Type, Print) Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 748M ROBERTA L. HARRISON 2019 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital at Easton Easton Talbot Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Min. Hours 220-34-7505 Director 1 □ M 2 🔀 F 74 9/26/1937 MARYLAND Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 □ No TALBOT TILGHMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21671 21441 DOGWOOD COVE ROAD permit. Page 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examinar anomals. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) RESTAURANT Elementary/Secondary (0-12) College (1-4 or 5+) OWNER HOSPITALITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ KATHARINE MARIE TRAINER ROBERT PRESTON LAMBDIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. BOX 310, TILGHMAN, MD 21671 LEVIN F. HARRISON, IV, SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOHN'S CEMETERY 8/7/2012 4 ☐ Donation 5 ☐ Other (Specify) TILGHMAN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 1
200 SOUTH HARRISON STREET, EASTON, MD 21601 MERCER 0 SOHOL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (OMMVNITY ACGVIVEG disease or condition resulting in death) drys Medical Due to (or as a cons ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director, page 2 should be detached for use as the build the completely filled in by the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NON /mall 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗗 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No |₽ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 31466 US 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 CYNWOOD DRIVE, EASTON, MD 21601 LUDWÍG J. ÆGLSEDER, III, MD

Registrar

31. Date filed (Month, Day, Year)

AUG U 2 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **4ugus** 20 E. CHRISTINA HOLLINGSHEAD Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HospITAL at EASTON FASTON TALBO EMORIAL Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Months Hours 212-40-0689 71 **Director** 1 🗆 M 2 🗶 F 11/30/1940 MARYLAND Usual Residence of Decedent 10b. Count ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director TALBOT EASTON 1 X Yes 2 □ No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21601 29712 PENNY LANE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, <u>the Me</u>ury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) 12 College (1-4 or 5+) TEACHER **EDUCATION** Be FOLLINGSHEAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES ALEXANDER KOFSKEY EDNA HOLM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH CHATHAM, DAUGHTER 29732 PENNY LANE, EASTON, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Important: If ite any Injury or oth 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 8/19/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MD 21601 NHAV  $\overline{\mathbf{x}}$ MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Failure Immediate Cause (Final Physician/ Acule disease or condition resulting in death) े Medical Due to (or as a consequence of) Examiner Hyperkalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. robable Sepsic ate has been signed by the attending physician and page 2 should be detached for use as the burial-tren that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Day a | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lower Extremit 1 Yes 2 No 3 Probably 4 Wunknown Fibrillation Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a Was an this certificate has Mellitus Diabetes Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mohan 15,2012 D0069567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RS 6 State

DHMH 17 Rev 06-2011

Registrar

RAVI MOHAN, MD

31. Date filed (Month, Day, Year) AUG 1 7 2012

32. Registrar's Signature

219 SOUTH WASHINGTON STREET, EASTON, MD

21601